Management of Nicotine Addiction Fact Sheet

MINIMAL CLINICAL INTERVENTIONS

- Helping people quit smoking can yield significant health and economic benefits. An estimated 70% of smokers (33.2 million) want to quit, but only 2.5% (1.2 million) per year succeed in quitting smoking permanently.[1,2]

- According to three study findings, nearly 70% of American smokers (36 million) make at least one outpatient visit each year, but health care providers gave smoking cessation advice to only 40% to 52% of the smokers.[3]

- One recent study reported that only 15% of smokers who saw a physician in the past year were offered assistance with quitting, and only 3% were given a follow-up appointment to address the problem.[3]

- In 1992, about half of all adult U.S. smokers visited a dentist, but only 25% were advised to quit by their dentist.[3]

- Effective strategies for treating tobacco use include brief advice by medical providers, counseling, and pharmacotherapy.[3]

- Advancements in treating tobacco use and nicotine addiction were summarized in a recent guideline, *Treating Tobacco Use and Dependence: A Clinical Practice Guideline*, published by the U.S. Public Health Service. The guideline provides a blueprint to health care professionals and health insurance providers for implementing appropriate medical services that will help treat nicotine addiction.[4]

- Less intensive interventions, as simple as physicians advising their patients to quit smoking, can produce cessation rates of 5% to 10% per year. More intensive interventions, combining behavioral counseling and pharmacologic treatment, can produce 20% to 25% quit rates in one year.[3]

- Self-help interventions, such as manuals, pamphlets, booklets, videos and audiotapes, and Internet/ computer programs, have had only modest and inconsistent success at helping smokers quit. However, self-help interventions can be delivered easily to smokers who want to quit on their own, and proactive telephone counseling may significantly increase their effectiveness.[4]

INTENSIVE CLINICAL INTERVENTIONS

- Intensive clinical interventions serve a relatively small population of smokers who find it most difficult to quit. Through various strategies they try to give smokers the knowledge and skills necessary to cope with cessation. Three types of counseling and behavioral therapies result in the highest abstinence rates: (1) teaching problem-solving skills; (2) providing social support as part of treatment; and (3) helping smokers obtain social support outside of treatment.[4]

- Rapid-smoking cessation strategies typically require that smokers inhale deeply from a cigarette about every 6 seconds until they become nauseated. In theory, this strategy changes smokers' perception of smoking from a pleasurable activity to an unpleasant one, thereby making it easier for them to quit.[4]

- Skills training, rapid smoking, and both intra- and extra-treatment social support have been associated with successful smoking cessation. When such treatments are shown to be effective, they usually are part of a multifactorial intervention.[4]

PHARMACOTHERAPY

- Pharmacotherapy is a vital element of a multicomponent approach. The PHS's guideline identifies five first-line medications (bupropion SR, nicotine gum, nicotine inhaler, nicotine nasal spray, and nicotine patch) and two second-line medications (clonidine and nortriptyline) for treating tobacco use.[4]

- First-line pharmacotherapies have been found to be safe and effective for treating tobacco dependence and have been approved by the U.S. Food and Drug Administration (FDA) for use. Second-line medications have shown evidence of efficacy for treating tobacco dependence, but they are not FDA approved and may cause potential side effects. Second-line treatments should be considered on a case-by-case basis only after first-line treatments have failed.[4]

- Bupropion, an antidepressant prescription medication, is the first non-nicotine medical smoking cessation aid. According to the PHS guidelines, bupropion is an effective aid in helping smokers to quit. In addition, bupropion is safe when used in conjunction with nicotine replacement therapy.[4]

- Nicotine gum is approved as an over-the-counter nicotine replacement product. Chewing the gum releases nicotine, which is absorbed through the mouth and mucous membranes. Nicotine gum is available in a 2-mg dose introduced in 1984 and a 4-mg dose introduced in 1994. The higher dose of nicotine gum may be a better aid for heavier smokers or for those highly dependent on nicotine.[4]

- Nicotine patches contain a reservoir of nicotine that diffuses through the skin and into the smoker's bloodstream at a constant rate. Patches are available both as over-the-counter and prescription medications.[4]

- Nicotine nasal spray was approved for prescription use in March 1996. The spray consists of a pocket-sized bottle and pump assembly, with a nozzle that is inserted into the nose. Each metered spray delivers 0.5 mg of nicotine to the nasal mucosa.[3,4]

- In May 1997 the nicotine inhaler was approved as a prescription medication to treat tobacco dependence. The inhaler consists of a plastic tube about the size of a cigarette and contains a plug filled with nicotine. Menthol is added to the plug to reduce throat irritation. Smokers puff on the inhaler as they would a cigarette. Each inhaler contains enough nicotine for 300 puffs.[3,4]

- Clonidine is used primarily to treat high blood pressure and has not been approved by the FDA as a smoking-cessation medication. Abrupt discontinuation of clonidine can result in nervousness, agitation, headache, and tremor accompanied or followed by a rapid rise in blood pressure. Therefore, clinicians need to be aware of potential side effects when prescribing this medication to smokers.[4]

- Nortriptyline is used primarily as an antidepressant and has not been evaluated or approved by the FDA as a smoking-cessation medication. The antidepressant produces a number of side effects, including sedation and dry mouth. It is recommended that nortriptyline be used only under the direction of a physician.[4]

TREATING OTHER TOBACCO USE

- Smokeless tobacco users should be strongly urged to quit and treated with the same cessation counseling interventions recommended to smokers. Clinicians delivering dental health services should conduct brief interventions with all smokeless tobacco users.[4]

- Users of cigars, pipes, and emerging novel tobacco products such as bidis and kreteks (clove cigarettes) should be urged to quit and offered the same counseling interventions recommended for smokers.[4]

ECONOMIC BENEFITS

- Cost-effectiveness analyses have shown that smoking cessation treatment compares favorably with hypertension treatment and other preventive interventions such as annual mammography, pap tests, colon cancer screening, and treatment of high levels of serum cholesterol.[3]

- Treating tobacco dependence is particularly important economically because smoking cessation can help prevent a variety of costly chronic diseases, including heart disease, cancer, and lung disease. In fact, smoking cessation treatment has been referred to as the "gold standard" of preventive interventions.[3]

- Progress has been made in recent years in disseminating clinical practice guidelines on smoking cessation. Healthy People 2010 calls for universal insurance coverage, both public and private, of evidence-based treatment for nicotine dependency for all patients who smoke.[3]

- The Centers for Disease Control and Prevention recommends that treatment for tobacco addiction should include (1) population-based counseling and treatment programs, such as cessation helplines; (2) adoption recommendations from the PHS clinical practice guideline; (3) coverage of treatment for tobacco dependence under both public and private insurance; and (4) elimination of cost barriers to treatment for underserved populations, particularly the uninsured.[5]

REFERENCES

1. Centers for Disease Control and Prevention. Cigarette smoking among adults–United States, 1993. MMWR 1994 43: 925-29.

2. Centers for Disease Control and Prevention. Smoking cessation during previous year among adults–United States, 1990 and 1991. MMWR 1993 42: 504-7.

3. U.S. Department of Health and Human Services. Reducing Tobacco Use: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000.

4. U.S. Department of Health and Human Services. Public Health Service. Treating Tobacco Use and Dependence. Clinical Practice Guideline. Rockville, MD, 2000.

5. Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs_1999. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1999.

Tobacco Advertising and Promotion Fact Sheet

- Despite the overwhelming evidence of the adverse health effects from tobacco use, efforts to prevent the onset or continuance of tobacco use face the pervasive challenge of promotion activity by the tobacco industry.[1]

- Regulating advertising and promotion, particularly that directed at young people, is very likely to reduce both the prevalence and initiation of smoking.[1]

- The tobacco industry uses a variety of marketing tools and strategies to influence consumer preference, thereby increasing market share and attracting new consumers.[1]

- Among all U.S. manufacturers, the tobacco industry is one of the most intense in marketing its products. Only the automobile industry markets its products more heavily.[1]

- In 1998 tobacco companies spent nearly $7 billion — or more than $18 million a day — to advertise and promote cigarettes. In recent years, these marketing dollars pay for activities that may have special appeal to young people.[2]

- Children and teenagers constitute the majority of all new smokers, and the industry's advertising and promotion campaigns often have special appeal to these young people.[1]

- One tobacco company, the Liggett Group, Inc., has admitted that the entire tobacco industry conspired to market cigarettes to children.[1]

- Tobacco documents recently obtained in litigation indicate that tobacco companies have purposefully marketed to children as young as 14 years of age.[1,4]

- About 85% of adolescent smokers who buy their own cigarettes buy either Marlboro, Newport, or Camel — the three most heavily advertised brands of cigarettes in the United States.[3]

- The effect of tobacco advertising on young people is best epitomized by R.J. Reynolds Company's introduction of the Joe Camel campaign. From the introduction of the "Old Joe" cartoon character in 1988, Camel's share of the adolescent cigarette market increased dramatically — from less than 1% before 1988, to 8% in 1989, to more than 13% in 1993.[1,4]

- In 1997 the Federal Trade Commission (FTC) filed a complaint against R.J. Reynolds alleging that "the purpose of the Joe Camel campaign was to reposition the Camel brand to make it attractive to young smokers...." The FTC ultimately dismissed its complaint after the November 23, 1998, Master Settlement Agreement (MSA), which calls for the ban of all cartoon characters, including Joe Camel, in the advertising, promotion, packaging, and labeling of any tobacco product.[1]

- The MSA prohibits a number of promotional activities such as banning brand name sponsorship of events with a significant youth audience; the use of tobacco brand names in stadiums and arenas; payments to promote tobacco products in movies, television shows, theater productions or live performances, videos and video games; all transit and outdoor advertising; and specialty items bearing product names and logos.

- The greatest growth of tobacco advertising aimed at women followed the introduction of Virginia Slims in 1968 with its slogan "You've Come a Long Way, Baby!" Since then, there has been an increasing number of cigarette brands and advertising campaigns targeted toward women.[5]

- In 1997 Woman Thing Music, a new record company owned by Philip Morris Tobacco Company, offered unsigned female music artists lucrative recording contracts and an opportunity to be featured on a new CD. This CD, targeted toward young women, was available only with the purchase of two packs of Virginia Slims cigarettes. Outraged by this promotion, the celebrity artists organized a counter-music campaign, Virginia SLAM.[6]

- In December 1999 Philip Morris launched a new $40 million campaign targeting women, particularly minority women, with the slogan "Find Your Own Voice." The ads have been featured in a variety of publications such as *Glamour*, *Ladies' Home Journal*, *People*, and *Essence*. In response to this ad campaign, several women's groups, led by the American Medical Women's Association and the National Coalition FOR Women AGAINST Tobacco, joined together on a campaign to counter the tobacco industry's targeting of women.[7,8]

- Many public health and smoking prevention groups are concerned about the tobacco industry's practice of targeting cultural and ethnic minorities through product development, packaging, pricing, advertising, and promotional activities.[1]

- A one-year study found that three major African American publications — *Ebony*, *Jet*, and *Essence* — received proportionately higher profits from cigarette advertisements than did other magazines.[8]

- Tobacco products are advertised and promoted disproportionately in racial/ethnic minority communities. Examples of targeted promotions include the introduction of cigarette products with the brand names "Rio" and "Dorado" that were advertised and marketed at different times to the Hispanic community.[8]

- Studies have found a higher density of tobacco billboards in racial/ethnic minority communities. For example, a 1993 study in San Diego, California, found that the highest proportion of tobacco billboards were posted in Asian American communities and the lowest proportion were in white communities.[8]

- The tobacco industry commonly uses cultural symbols and designs to target racial/ethnic populations. American Spirit cigarettes were promoted as "natural" cigarettes; the package featured an American Indian smoking a pipe. In addition, certain tobacco product advertisements have used visual images, such as American Indian warriors, to target their products.[8]

REFERENCES

1. U.S. Department of Health and Human Services. Reducing Tobacco Use: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000.

2. Federal Trade Commission Report to Congress for 1998, Pursuant to the Federal Cigarette Labeling and Advertising Act. Issued: 2000.

3. The University of Michigan. Cigarette Brands Smoked By American Teens: One Brand Predominates; Three Account for Nearly All Teen Smoking (press release). April 14, 1999.

4. Centers for Disease Control and Prevention. Trends in smoking initiation among adolescents and young adults–United States, 1980-1989. MMWR 1995; 44: 521-25.

5. O'Keefe AM, Pollay RW. Deadly targeting of women in promoting cigarettes. JAMWA 1996; No. 1&2:67-69.

6. Centers for Disease Control and Prevention. "SLAM" (educational video). Issued 2000.

7. Pollack J. Virginia Slims translates theme for many cultures: cigarette brand's $40 mil effort may be historic; uses multipage magazine. Advertising Age 1999 Sept 13; 70:3, 73.

8. American Medical Women's Association (press release) National Coalition FOR Women AGAINST Tobacco Launches Defense Against the Tobacco Industry. October 12, 1999.

9. U.S. Department of Health and Human Services. Tobacco Use Among U.S. Racial/Ethnic Minority Groups — African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1998.

Tobacco Products Fact Sheet

- More than 4,000 chemical compounds have been identified in tobacco smoke. Of these, at least 43 are known to cause cancer.[1]

- Current tobacco product regulation requires cigarette manufacturers to disclose levels of tar and nicotine. Smokers receive very little information regarding chemical constituents in tobacco smoke, however, and the use of terms such as "light" and "ultra light" on packaging and in advertising may be misleading.[1]

- Cigarettes with low tar and nicotine contents are not substantially less hazardous than higher–yield brands. Consumers may be misled by the implied promise of reduced toxicity underlying the marketing of such brands.[1]

- Vents are used in cigarette filters to lower tar and nicotine yields in smoke, but they may be difficult to see. To examine the vents in some brands, the smoker would have to take off the filter wrapping, hold the filter up to a bright light, and look through a magnifying glass.[2]

- The potential health benefit of low tar cigarettes has been challenged. Smokers who switch to lower–tar and –nicotine cigarettes frequently change their smoking habits. They may block the vents in the filter portion of a cigarette, puff more frequently, inhale more deeply, or smoke more cigarettes per day, thus negating any risk reduction from low–tar and –nicotine cigarettes.[2]

- Early data showed a lower cancer risk from low–tar cigarettes; however, more recent data suggest otherwise. Lower–yield cigarettes may be somewhat better than very high–yield cigarettes; but, when comparing full–flavor cigarettes and current light cigarettes, there is no evidence to suggest a lower cancer risk from the low–tar cigarettes.[1]

CIGARETTE ADDITIVES

- Federal law (the Comprehensive Smoking Education Act of 1984 and the Comprehensive Smokeless Tobacco Health Education Act of 1986) requires cigarette and smokeless tobacco manufacturers to submit a list of ingredients added to tobacco to the Secretary of Health and Human Services.[1]

- Hundreds of ingredients are used in the manufacture of tobacco products. Additives make cigarettes more acceptable to the consumer — they make cigarettes milder and easier to inhale, improve taste, and prolong burning and shelf life.[1]

- In 1994 six major cigarette manufacturers reported 599 ingredients that were added to the tobacco of manufactured cigarettes. Although, these ingredients are regarded as safe when ingested in foods, some may form carcinogens when heated or burned.[1]

- Knowledge about the impact of additives in tobacco products is negligible and will remain so as long as brand-specific information on the identity and quantity of additives is unavailable.[1]

SMOKELESS ADDITIVES

- In 1994 ten manufacturers of smokeless tobacco products released a list of additives used in their products. The additives list contained 562 ingredients approved for foods by the FDA.[1]

- The list of additives to smokeless tobacco includes sodium carbonate and ammonium carbonate, which increase the level of "free" nicotine in moist snuff by raising the pH level. Unprotonated (free) nicotine is the chemical form of nicotine that is most readily absorbed through the mouth into the bloodstream. Therefore, increases in pH can increase the snuff user's nicotine absorption rate. Studies with nicotine and other addictive drugs suggest that the absorption rate of drugs into the body is an important determinant of their addiction potential.[3]

- Moist snuff products with low nicotine content and pH levels have a smaller proportion of free nicotine. In contrast, moist snuff products with high nicotine content and pH levels have a higher proportion of free nicotine.[1]

- The epidemiology of moist snuff use among teenagers and young adults indicates that most novices start with brands having low levels of free nicotine and then "graduate" to brands with higher levels.[1]

- Sweeteners and flavorings, such as cherry juice concentrate, apple juice, chocolate liqueur, or honey are used in various smokeless tobacco products. As with manufactured cigarettes, these additives increase palatability and may increase the use of smokeless tobacco, at least among novices.[1]

REFERENCES

1. U.S. Department of Health and Human Services. Reducing Tobacco Use: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000.

2. Centers for Disease Control and Prevention. Filter ventilation levels in selected U.S. cigarettes, 1997. MMWR 1997; 46:1043-47.

3. Centers for Disease Control and Prevention. Determination of nicotine, pH, and moisture content of six U.S. commercial moist snuff products — Florida, January–February 1999. MMWR 1999; 48:398-401.

Comprehensive Programs Fact Sheet

RATIONALE FOR COMPREHENSIVE INTERVENTIONS

- Statewide programs have emerged as the new laboratory for developing and evaluating comprehensive plans to reduce tobacco use.

- Initial results from statewide tobacco control programs are encouraging, particularly in per capita declines of tobacco consumption.

- State findings also suggest that youth behaviors regarding tobacco use are more difficult to change than adult ones.

- People do not make behavior choices in isolation, but rather in a larger, complex context that includes the family, community, and culture; the economy and physical environment; formal and informal government policy; and the prevailing legal atmosphere. Programs to reduce tobacco use will be most effective if they address all the components that may influence the individual's behavior choices.

- There are several advantages to shifting from an approach that targets the individual to a population approach that uses social, policy, and environmental strategies.

- First, by recognizing that many environmental determinants of health behavior are not under the direct control of the individual, the population approach avoids blaming persons who fail to change their behavior.

- Second, many individual efforts may fail to reach those in greatest need. Because many of these strategies are most effective with better-educated, wealthier persons, the disparities in health between population groups may widen.

- Third, making regulatory and policy changes can be more cost-effective than conducting numerous interventions to modify individual behavior.

CDC'S NATIONAL TOBACCO CONTROL PROGRAM

- In May 1999 CDC launched the National Tobacco Control Program (NTCP), bringing the various federal initiative activities into one national program. In fiscal year 2000, the NTCP distributed $59 million for comprehensive tobacco control efforts in all states, the District of Columbia, seven U.S. territories, and Native American tribal organizations.

- CDC recommends four program goals in its comprehensive framework for statewide programs:[4]
  1. Prevent initiation of tobacco use among young people.
  2. Promote quitting among adults and young people.
  3. Eliminate exposure to environmental tobacco smoke (ETS).
  4. Identify and eliminate health disparities among population groups.

- Each program goal would be fully addressed by implementing four program components:
  1. community interventions, which include diverse entities such as schools, health agencies, city and county governments, and civic, social, and recreational organizations;
  2. countermarketing, which includes using media advocacy, paid media, pro-health promotions, and other media strategies to change social norms related to tobacco use;
  3. program policy and regulation, which addresses such issues as minors' access, tobacco pricing, advertising and promotion, clean indoor air, product regulation, and tobacco use treatment; and
  4. surveillance and evaluation, which includes monitoring the tobacco industry's promotional campaigns, evaluating the economic impact of ETS laws and policies, conducting surveys of public opinion on program interventions, and making ongoing refinements that lead to more effective prevention strategies.

- The elimination of health disparities among population groups remains a challenge due to the lack of culturally appropriate programs of proven efficacy. However, in recent years, a number of people and organizations with more diverse backgrounds have assumed a greater role in efforts to reduce tobacco use. Particularly in view of the tobacco industry's targeted marketing to women, young people, and racial/ethnic populations, such heightened activity is critically important for ensuring that nonsmoking becomes the norm within diverse communities.

- To be effective, comprehensive programs should include campaigns that:
  1. target young people and adults with complementary messages;
  2. highlight nonsmoking as the majority behavior;
  3. communicate the dangers of tobacco while providing constructive alternatives;
  4. use multiple non-preachy voices in a complementary, reinforcing mix of media and outdoor advertising;
  5. include grassroots promotions, local media advocacy, event sponsorships, and other community tie-ins; and
  6. encourage youth empowerment and involvement.

Education Fact Sheet

- The high rate of cigarette, smokeless tobacco, and cigar use among youth, along with the emergence of novel tobacco products such as bidis (or beedies) and kreteks (also known as clove cigarettes), suggests that a major proportion of U.S. youth already exhibit or are at risk for nicotine addiction and the subsequent health problems caused by tobacco use.[1]

- More than 4 million adolescents under the age of 18 in the United States smoke cigarettes.[2] Each day, more than 6,000 young people try a cigarette and nearly 3,000 become regular smokers — that adds up to more than one million new smokers each year.[3]

- In 1999 more than one-third (34.8%) of U.S. high school students in grades 9 through 12 reported smoking cigarettes in the past month. Data from 1995 (34.8%) and 1997 (36.4%) show that current smoking prevalence rates among high school students remain high but appear to have plateaued.[4]

- Many factors interact to encourage tobacco use among youth, including tobacco advertising and promotion, tobacco use by peers and family members, and easy access to tobacco products.[6]

- Early adolescence (age 11-15 years, or sixth through tenth grade) is the period when young people are most likely to try smoking for the first time.[6]

- Tobacco-free policies involving the school's faculty, staff, and students have a critical role in reducing tobacco use among young people, especially when these policies apply to all school facilities, property, vehicles, and school-sponsored events. While two-thirds of schools (62.8%) had smoke-free building policies in 1994, significantly fewer (36.5%) reported having policies that included the entire school environment.[6]

- Adopting strong tobacco-free policies are only the first step. Schools should rigorously enforce these policies to protect children from the hazards of tobacco smoke at school, to model a tobacco-free environment, and to reduce opportunities for young people to experiment with tobacco on school grounds.

- Implementing effective educational programs for preventing tobacco use could postpone or prevent smoking onset in 20% to 40% of U.S. adolescents.[6]

- Programs with the most educational contacts during the critical years for smoking adoption (age 11-15 years) are more likely to be effective, as are programs that address a broad range of educational needs.[6]

- Educational strategies to prevent tobacco use must become more consistent and effective. This will require continuing efforts to build strong, multi-year prevention units into school health education curricula. It will also require expanded efforts to make use of the influence of parents, the mass media, and community resources.[6]

- Existing data suggest that evidence-based curricula and national guidelines have not been widely adopted. Less than 5% of schools nationwide are implementing the major components of CDC's Guidelines for School Health Programs to Prevent Tobacco Use and Addiction, which recommends schools should: [6]
  - Develop and enforce a school policy on tobacco use.
  - Provide instruction about the short- and long-term effects of tobacco use, social influences on tobacco use, peer norms regarding tobacco use, and refusal skills.
  - Provide tobacco-use prevention education in kindergarten through 12th grade, with especially intensive instruction in junior high or middle school.
  - Provide program-specific training for teachers.
  - Involve parents and families in support of school-based programs to prevent tobacco use.
  - Support cessation efforts among students and school staff who use tobacco.
  - Assess the tobacco-use prevention program at regular intervals.

- Educational curricula that address social influences (of friends, family, and media) that encourage tobacco use among youth, have shown consistently more effectiveness than programs based on other models.[6]

- Two middle school programs that have demonstrated effectiveness in reducing tobacco use behaviors in youth have been identified by the Centers for Disease Control and Prevention as programs that work, and they are Life Skills Training Program, and Project Toward No Tobacco (TNT).[6]

- Schools can not bear the sole responsibility for preventing tobacco use. School-based programs are more effective when combined with mass media programs and with community-based efforts involving parents and other community resources.[6]

REFERENCES

1. Centers for Disease Control and Prevention. Tobacco use among middle and high school students — United States, 1999. MMWR; 49:49-53.

2. Substance Abuse and Mental Health Services Administration. Annual national drug survey results from the 1998 National Household Survey on Drug Abuse. Office of Applied Studies, August 1999.

3. Centers for Disease Control and Prevention. Incidence of Initiation of Cigarette Smoking — United States, 1965-1996. MMWR; 47:837-840.

4. Centers for Disease Control and Prevention. Youth risk behavior surveillance — United States, 1999. MMWR; 49 (SS-5).

5. Centers for Disease Control and Prevention. Preventing Tobacco Use Among Young People: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, 1994, pages 129-131,166, and 248-249.

6. U.S. Department of Health and Human Services. Reducing Tobacco Use: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000.

Clean Indoor Air Regulations Fact Sheet

MINIMAL CLINICAL INTERVENTIONS

- As reported in 1992 by the U.S. Environmental Protection Agency (EPA), exposure to tobacco smoke in the environment can cause lung cancer in adult nonsmokers. Environmental tobacco smoke (ETS) also has been linked to an increased risk of heart disease among nonsmokers.

- ETS causes about 3,000 lung cancer deaths annually among adult nonsmokers.

- In 1997, the California EPA concluded that ETS causes coronary heart disease and death in nonsmokers. Scientific studies have estimated that ETS accounts for as many as 62,000 deaths from coronary heart disease annually in the United States.

- The 1992 EPA report also concluded that ETS causes serious respiratory problems in children, such as greater number and severity of asthma attacks and lower respiratory tract infections. ETS exposure increases children's risk for sudden infant death syndrome (SIDS) and middle ear infections as well.

- Each year ETS causes 150,000-300,000 lower respiratory tract infections, such as pneumonia and bronchitis, in children.

- In a large U.S. study, maternal exposure during pregnancy and postnatal exposure of the newborn to ETS increased the risk for SIDS.

- Comparative risk studies performed by the EPA have consistently found ETS to be a risk to public health. ETS is classified as a group A carcinogen (known to cause cancer in humans) under the EPA's carcinogen assessment guidelines.

- Several studies have documented the widespread exposure of ETS among nonsmoking adults and children in the United States. Testing nonsmokers' blood for the presence of cotinine, a chemical produced when the body metabolizes nicotine, shows that nearly 9 out of 10 nonsmoking Americans (88%) are exposed to ETS.

- A 1988 National Health Interview Survey reported that an estimated 37% of the 79.2 million nonsmoking U.S. workers were employed in places that permitted smoking in designated areas, and that 59% of these workers experienced moderate or great discomfort from ETS exposure in the workplace.

- Under common law (laws based on court decisions rather than government laws and regulations), employers must provide a work environment that is reasonably free of recognized hazards. Courts have ruled that common-law duty requires employers to provide nonsmoking employees protection from the proven health hazards of ETS exposure.

- The Occupational Safety and Health Administration is considering regulations that would either prohibit smoking in all workplaces or limit it to separately ventilated areas.

- The federal government has instituted increasingly stringent regulations on smoking in its own facilities. On August 9, 1997, President Clinton signed an Executive Order declaring that Executive Branch federal worksites be smoke-free, thereby protecting nonsmoking federal employees and thousands of citizens who visit federal facilities from the dangers of ETS.

- The Pro-Children's Act of 1994 (Public Law 103-227, secs. 1041-1044) prohibits smoking in facilities where federally funded children's services are provided on a regular or routine basis.

- As of December 31, 1999, at least some degree of smoke-free indoor air laws were present in 45 states and the District of Columbia. These laws vary widely, from limited smoking restrictions on public transportation to comprehensive restrictions in worksites and public places.

- Twenty states and the District of Columbia limit smoking in private worksites. Of these states, only one (California) meets the nation's Healthy People 2010 objective to eliminate exposure to ETS by either banning indoor smoking or limiting it to separately ventilated areas.

- Forty-one states and the District of Columbia have laws restricting smoking in state government worksites, but only 13 of these states meet the nation's Healthy People 2010 objective.

- Thirty-one states have laws that regulate smoking in restaurants; of these, only Utah and Vermont completely prohibit smoking in restaurants. California requires either a no smoking area or separate ventilation for smoking areas.

ADDITIONAL BENEFITS

- An additional benefit of clean indoor air regulations may contribute to a reduction in smoking prevalence among workers and the general public. Studies have found that moderate or extensive laws for clean indoor air are associated with a lower smoking prevalence and higher quit rates.

- The majority of smokers support smoke-free hospitals. Smokers and nonsmokers were in favor of smoke-free workplace six months after a smoke-free policy was implemented.

- Employers are likely to save money by implementing policies for smoke-free workplaces. Savings include costs associated with such things as fire risk, damage to property and furnishings, cleaning, workers' compensation, disability, retirement, injuries, and life insurance. Cost savings were estimated at $1,000 per smoking employee based on 1988 dollars.

- The EPA estimates a nationwide, comprehensive policy on clean indoor air would save $4 billion to $8 billion per year in building operations and maintenance costs.

ESTABLISHING PUBLIC POLICY

- Involuntary exposure to ETS remains a common public health hazard that is entirely preventable by adopting appropriate regulatory policies.

- To fight the establishment of such policies, the tobacco industry tries to shift the focus from the science-based evidence on the health hazards of ETS to the controversial social issue of personal freedom. The industry has lobbied extensively against legislation to restrict smoking, and has supported the passage of state laws that preempt stronger local ordinances. (Preemptive legislation is defined as legislation that prevents a local jurisdiction from enacting laws more stringent than, or at a variance with, the state law.)

- A case study conducted in six states found that the existence of an organized smoking prevention coalition among local citizens was a key determinant in successfully enacting clean indoor air legislation.

- Smokefree environments are the most effective method for reducing ETS exposure. Healthy People 2010 objectives address this issue and seek optimal protection of nonsmokers through policies, regulations, and laws requiring smoke-free environments in all schools, work sites, and public places.

U.S. Tobacco Exports Fact Sheet

MINIMAL CLINICAL INTERVENTIONS

- Tobacco use remains the leading cause of preventable illness and death in the United States, and a growing number of other countries are experiencing the health burdens of tobacco use.

- Globally, smoking-related deaths will rise to 10 million per year by 2030, with 7 million of these deaths occurring in developing countries. For the first time, the United States and other countries are collaborating to create an international framework designed to stem the global epidemic of tobacco-related death and disease.

- On February 17, 1998, President Clinton issued a directive on the U.S. foreign tobacco policy to all diplomatic posts. The directive states that the U.S. Government will not promote the sale or export of tobacco and tobacco products abroad. The directive also states that the U.S. Government supports tobacco control efforts of foreign governments and their people and specifically directs diplomatic personnel to facilitate those efforts.

- In general, U.S. tobacco exports are specifically exempted from federal laws and regulations concerning the export of potentially harmful products. The Federal Government has no regulations or laws governing the packaging or advertising of cigarettes produced domestically for export.

- The threat of retaliatory trade sanctions has successfully opened some foreign markets to U.S. cigarette manufacturers, thereby significantly expanding trade in tobacco products between the United States and other countries. In 1991 the market share of U.S. cigarette companies increased by an average of 600 percent in countries affected by the threat of trade sanctions.

- In 1998 the United States exported 539 million pounds of tobacco leaves. The largest export markets for U.S.-grown tobacco in recent years have been Japan, Germany, the Netherlands, and Turkey.

- Although acreage devoted to tobacco farming has fallen worldwide, technological improvements have led to overall increases in tobacco production. In 1999 growers around the world produced more than six million metric tons of tobacco. Four countries accounted for more than 60% of this production: China (34.9%), India (9.7%), the United States (9.4%), and Brazil (8.2%).

- In some producing countries, such as Zimbabwe, nearly all tobacco production is exported.

- An estimated 85% of the world's tobacco crop is used for cigarettes. In 1996, cigarette manufacturers around the world produced nearly 6 trillion cigarettes. These areas accounted for more than half of this production: China, Europe, and the United States. Although cigarette consumption is falling in industrialized countries, global consumption is rising because of significant increases in developing countries.

- World trade in cigarettes has grown steadily for at least the past 30 years. U.S. cigarette firms capitalized on this growth, expanding cigarette exports from an average of 24.3 billion per year in the late 1960s to a peak of almost 250 billion in 1996; as a result, domestic cigarette production rose even as domestic sales were declining. Through the 1990s, nearly 30 percent of all cigarettes produced in the United States were exported.

- The implementation of multinational agreements liberalizing trade, including trade in tobacco and tobacco products, is likely to further increase U.S. exports of tobacco and tobacco products to countries around the world. A probable consequence of this increase is that the prices of cigarettes and other tobacco products will fall due to enhanced competition. Lower prices could stimulate the use of cigarettes, particularly among adolescents and young adults.

- Nicotine gum is approved as an over-the-counter nicotine replacement product. Chewing the gum releases nicotine, which is absorbed through the mouth and mucous membranes. Nicotine gum is available in a 2-mg dose introduced in 1984 and a 4-mg dose introduced in 1994. The higher dose of nicotine gum may be a better aid for heavier smokers or for those highly dependent on nicotine.[4]

- Nicotine patches contain a reservoir of nicotine that diffuses through the skin and into the smoker's bloodstream at a constant rate. Patches are available both as over-the-counter and prescription medications.[4]

- Nicotine nasal spray was approved for prescription use in March 1996. The spray consists of a pocket-sized bottle and pump assembly, with a nozzle that is inserted into the nose. Each metered spray delivers 0.5 mg of nicotine to the nasal mucosa.[3,4]

- In May 1997 the nicotine inhaler was approved as a prescription medication to treat tobacco dependence. The inhaler consists of a plastic tube about the size of a cigarette and contains a plug filled with nicotine. Menthol is added to the plug to reduce throat irritation. Smokers puff on the inhaler as they would a cigarette. Each inhaler contains enough nicotine for 300 puffs.[3,4]

- Clonidine is used primarily to treat high blood pressure and has not been approved by the FDA as a smoking-cessation medication. Abrupt discontinuation of clonidine can result in nervousness, agitation, headache, and tremor accompanied or followed by a rapid rise in blood pressure. Therefore, clinicians need to be aware of potential side effects when prescribing this medication to smokers.[4]

- Nortriptyline is used primarily as an antidepressant and has not been evaluated or approved by the FDA as a smoking-cessation medication. The antidepressant produces a number of side effects, including sedation and dry mouth. It is recommended that nortriptyline be used only under the direction of a physician.[4]

TREATING OTHER TOBACCO USE

- Smokeless tobacco users should be strongly urged to quit and treated with the same cessation counseling interventions recommended to smokers. Clinicians delivering dental health services should conduct brief interventions with all smokeless tobacco users.[4]

- Users of cigars, pipes, and emerging novel tobacco products such as bidis and kreteks (clove cigarettes) should be urged to quit and offered the same counseling interventions recommended for smokers.[4]

ECONOMIC BENEFITS

- Cost-effectiveness analyses have shown that smoking cessation treatment compares favorably with hypertension treatment and other preventive interventions such as annual mammography, pap tests, colon cancer screening, and treatment of high levels of serum cholesterol.[3]

- Treating tobacco dependence is particularly important economically because smoking cessation can help prevent a variety of costly chronic diseases, including heart disease, cancer, and lung disease. In fact, smoking cessation treatment has been referred to as the "gold standard" of preventive interventions.[3]

- Progress has been made in recent years in disseminating clinical practice guidelines on smoking cessation. Healthy People 2010 calls for universal insurance coverage, both public and private, of evidence-based treatment for nicotine dependency for all patients who smoke.[3]

- The Centers for Disease Control and Prevention recommends that treatment for tobacco addiction should include (1) population-based counseling and treatment programs, such as cessation helplines; (2) adoption recommendations from the PHS clinical practice guideline; (3) coverage of treatment for tobacco dependence under both public and private insurance; and (4) elimination of cost barriers to treatment for underserved populations, particularly the uninsured.[5]

REFERENCES

1. Centers for Disease Control and Prevention. Cigarette smoking among adults–United States, 1993. MMWR 1994 43: 925-29.

2. Centers for Disease Control and Prevention. Smoking cessation during previous year among adults–United States, 1990 and 1991. MMWR 1993 42: 504-7.

3. U.S. Department of Health and Human Services. Reducing Tobacco Use: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000.

4. U.S. Department of Health and Human Services. Public Health Service. Treating Tobacco Use and Dependence. Clinical Practice Guideline. Rockville, MD, 2000.

5. Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs_1999. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1999.

Historical Fact Sheet

- Cigarettes were first introduced in the United States in the early 19th century. Before this, tobacco was used primarily in pipes and cigars, by chewing, and in snuff.[1]

- By the time of the Civil War, cigarette use had become more popular. Federal tax was first imposed on cigarettes in 1864. Shortly afterwards, the development of the cigarette manufacturing industry led to their quickly becoming a major U.S. tobacco product.[1]

- At the same time, the populist health reform movement led to early anti-smoking activity. From 1880-1920, this activity was largely motivated by moral and hygienic concerns rather than health issues.[1]

- The milder flue-cured tobacco blends used in cigarettes during the early 20th century made the smoke easier to inhale and increased nicotine absorption into the bloodstream.[1]

- During World War I, Army surgeons praised cigarettes for helping the wounded relax and easing their pain.[1]

- Smoking was first linked to lung cancer and other diseases in the late 1940s and early 1950s.[1]

- In 1956, a Surgeon General's scientific study group determined that there was a causal relationship between excessive cigarette smoking and lung cancer.[1]

- In England, the 1962 Royal College of Physicians report emphasized smoking's causative role in lung cancer.[1]

- On January 11, 1964, the first-ever Surgeon General's Report on Smoking and Health concluded that cigarette smoking is a cause of lung cancer in men.[2]

- In 1965 Congress passed the Federal Cigarette Labeling and Advertising Act requiring health warnings on all cigarette packages.[3]

- In 1967 the Federal Communications Commission ruled that the Fairness Doctrine applies to cigarette advertising and that radio and television stations broadcasting cigarette commercials must donate equal air time to anti-smoking messages.[3]

- Anti-smoking messages had a significant impact on cigarette sales; however, when cigarette advertising on television and radio was banned in 1969, anti-smoking messages were discontinued.[1]

- The 1972 Surgeon General's report became the first of a series of science-based reports to identify environmental tobacco smoke (ETS) as a health risk to nonsmokers.[1]

- In 1973 Arizona became the first state to restrict smoking in a number of public places explicitly because ETS exposure is a public hazard.[1]

- By the mid-1970s, the federal government began administratively regulating smoking within government domains. In 1975, the Army and Navy stopped including cigarettes in rations for service members. Smoking was restricted in all federal government facilities in 1979 and was banned in the White House in 1993.[1]

- In 1988 Congress prohibited smoking on domestic commercial airline flights scheduled for 2 hours or less. By 1990, the ban was extended to all commercial U.S. flights.[1]

- In 1992 the Environmental Protection Agency (EPA) classified ETS as a "Group A" carcinogen, the most dangerous class of carcinogen.[1]

- In 1994 six major U.S. cigarette manufacturers testified before Congress that nicotine is not addictive and that they do not manipulate nicotine in cigarettes.[4]

- Food and Drug Administration (FDA) Commissioner David A. Kessler, M.D., testified before a congressional subcommittee in 1994 that cigarettes may qualify as drug-delivery systems, bringing them within the jurisdiction of the FDA. The following year, Dr. Kessler declared tobacco use a "pediatric disease." [4]

- In 1994 Mississippi became the first state to sue the tobacco industry to recover Medicaid costs for tobacco-related illnesses, settling its suit in 1997. A total of 46 states eventually filed similar suits. Three other states settled individually with the tobacco industry — Florida (1997), Texas (1998), and Minnesota (1998).[1,4]

- In 1995 the Department of Justice reached an agreement with Philip Morris to remove tobacco advertisements from the line of sight of television cameras in sports stadiums to ensure compliance with the federal ban on tobacco ads on television.[4]

- On August 23, 1996, President Clinton announced the release of the FDA's rule regulating tobacco sales and marketing aimed at minors.[4]

- In 1996 the Liggett Group, the smallest of the nation's five major tobacco companies, offered to settle a class action suit by taking financial responsibility for tobacco-related diseases and death for the first time.[4]

- In 1996 the FDA approved nicotine gum and two nicotine patches for over-the-counter sale to increase their availability to smokers who want to quit. The U.S. Public Health Service released its Smoking Cessation Clinical Practice Guidelines for clinicians.[4]

- On June 20, 1997, all major U.S. tobacco companies signed an agreement that would have restricted tobacco advertising, put cigarettes and chewing tobacco behind retail counters, restricted smoking in public places, and created a national education campaign. This settlement would have required the tobacco industry to expend $360 billion over 25 years. The June 1997 settlement required Congressional approval; however, this was never approved.[6,7]

- On April 1, 1998, the Senate Commerce Committee voted in favor of the McCain bill, which gave complete authority to the FDA to regulate nicotine as a drug. It also raised the cigarette tax by $1.10 per pack and mandated penalties for the industry if specific targets for reducing youth smoking levels were not met. The bill was defeated by the full Senate in June 1998.[5]

- On November 23, 1998, the tobacco industry approved to a 46-state Master Settlement Agreement, the largest settlement in history, totaling nearly $206 billion to be paid through the year 2025. The settlement agreement contained a number of important public health provisions.[1]

- In April 1999, as part of the Master Settlement Agreement, the major U.S. tobacco companies agreed to remove all advertising from outdoor and transit billboards across the nation. The remaining time on at least 3,000 billboard leases, valued at $100 million, was turned over to the states for posting anti-tobacco messages.[1]

- On March 21, 2000, the U.S. Supreme Court narrowly affirmed a 1998 decision of the U.S. Court of Appeals for the 4th Circuit and ruled that the FDA lacks jurisdiction under the Federal Food, Drug, and Cosmetic Act to regulate tobacco products. As a result, the FDA's proposed rule to reduce access and appeal of tobacco products for young people became invalid.[1]

- In July 2000 a Florida jury ordered the tobacco industry to pay $145 billion in punitive damages to sick Florida smokers. The tobacco industry is appealing verdict.

REFERENCES

1. U.S. Department of Health and Human Services. Reducing Tobacco Use: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000.

2. U.S. Department of Health, Education, and Welfare Smoking and Health: Report of the Advisory Committee to the Surgeon to the Surgeon General of the Public Health Service. Washington: U.S. Department of Health, Education, and Welfare, Public Health Service, 1964. PHS Publication No. 1103.

3. U.S. Department of Health and Human Services. Reducing the Health Consequences of Smoking: 25 Years of Progress. A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1989. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Office on Smoking and Health. Significant Developments Related to Smoking and Health.

4. Campaign for Tobacco-Free Kids. Special Reports Year in Review 1998, http://tobaccofreekids.org/reports/yearsinreview/1998inreview.shtml.

5. USA Today. Tobacco Settlement: Tobacco chronology, http://www.usatoday.com/news/smoke/ smoke26.htm.

6. Campaign for Tobacco-Free Kids. Special Reports Year in Review 1997.

7. U.S. Department of Health and Human Services, HHS News, Tobacco Billboards Replaced with Pro-Health Messages, 1999, http://waisgate.hhs.gov/cgi-bin/waisgate?WAISdocID=1249123940+10+0+0&WAISaction=retrieve.

Minors' Access to Tobacco Fact Sheet

- It is illegal in all states to sell cigarettes to persons under age 18. Progress has been made in the past several years in reducing the percentage of retailers willing to sell tobacco to minors.[1]

- In 1991 an estimated 225 million packs of cigarettes were sold illegally to minors, and in 1997 daily smokers aged 12 to 17 years smoked approximately 924 million packs of cigarettes.[1]

- An estimated 20% to 70% of teenagers who smoke report purchasing their own tobacco; the proportion varies by age, social class, amount smoked, and factors related to availability.[1]

- The CDC's 1999 Youth Risk Behavior Surveillance (YRBS) survey found that among grade 9-12 students who smoked, 23.5% purchased their tobacco products from a store or gas station. However, there is growing evidence that many of the cigarettes these students obtain from other students were originally illegally sold to minors.[2]

- According to the 1999 YRBS survey, about two-thirds of students (69.6%) who purchased or tried to purchase cigarettes during the past month in a store or gas station were not asked to show proof of age. African American male students (19.8%) were significantly less likely to be asked to show proof of age than white (36.6%) and Hispanic (53.5%) male students.[2]

- The 1999 Monitoring the Future Survey found that about 72% of 8th-grade students and 88% of 10th-grade students believe they can get cigarettes "fairly easily" or "very easily" if they wanted to purchase them.[3]

- Since 1996, the accessibility of cigarettes among 8th-grade students has been falling, which may be an indicator that federal and state government tobacco prevention efforts are starting to have an effect.[3]

- More than two-thirds of states restrict cigarette vending machines, but many of these restrictions are weak. Only two states (Idaho and Vermont) have total bans on vending machines.[1]

- Results from nine published studies found illegal vending machine sales to minors ranged from 82% to 100% between 1989 and 1992.[1]

- More than 290 local jurisdictions, including New York City, successfully adopted and enforced outright bans on cigarette vending machines or restricted them to locations such as taverns and adult clubs where minors often are denied entry.[1]

- Almost two-thirds of the states and many local jurisdictions require retailers to display signs that state the minimum age for purchase of tobacco products. Some regulations specify the size, wording, and location of these signs.[1]

- All states have a specific restriction on the distribution of free tobacco samples to minors, and a few states or local jurisdictions prohibit free distribution altogether because of the difficulty of controlling who receives free samples.[1]

- Several studies have found that single or loose cigarettes are sold in some locations. Such sales often are prohibited by state or local law, given single cigarettes do not display the required state tax stamp or federal health warning.[1]

- Other regulations specify a minimum age for salespersons. These regulations recognize the difficulty young salespersons may have in refusing to sell cigarettes to their peers.[1]

- Many state or local laws specify penalties only for the salesperson. However, applying penalties to business owners, who generally set hiring, training, supervising, and selling policies, is considered essential to preventing the sale of tobacco to minors.[1]

- License suspensions or revocations imposed as penalties for repeated violation of youth access laws would communicate a clear message that illegal tobacco sales to minors should never be accepted or tolerated. Revenues from fines could be used for enforcement and retailer education programs.[1]

- Numerous studies have shown that comprehensive merchant education and training programs help reduce illegal sales to minors.[1]

- Growing number of states and local jurisdictions are imposing sanctions against minors who purchase, attempt to purchase, or possess tobacco products. Although these laws are a potential deterrent, some tobacco control advocates believe such laws deflect responsibility from retailers to underage youth.[1]

- In 1992 the Synar Amendment (Public Law 102-321), was passed to curb the illegal sale of tobacco products to minors. An amended Synar Regulation, was issued by the Substance Abuse and Mental Health Services Administration in January 1996, and requires each state receiving federal grant money to conduct annual random, unannounced inspections of retail tobacco outlets to assess the extent of sales to minors. In 1999, seven states and the District of Columbia failed to attain their Synar Amendment targets. Failure to comply with the law puts states at risk of forfeiting federal block grant funds for substance abuse prevention and treatment services.[1]

- In 1996, the Food and Drug Administration issued a regulation prohibiting the sale of tobacco products to persons under the age of 18 years and requiring that all persons under the age of 27 years show a photograph identification to purchase cigarettes or smokeless tobacco. The regulation also banned cigarette vending machines and self-service displays, except in certain venues for adults only (e.g., bars and nightclubs).

- On March 21, 2000, the United States Supreme Court ruled that the FDA lacked jurisdiction to regulate tobacco products and to enforce rules to reduce the access and appeal of tobacco products for children and adolescents. The loss of the FDA's education and enforcement program eliminates vital federal support for state tobacco control programs.[1]

- The 2010 national health objectives call for reducing the percentage of retailers willing to sell tobacco products to minors to 5% or less through enforcement of existing laws. To date, no state has met this objective.[4]

REFERENCES

1. U.S. Department of Health and Human Services. Reducing Tobacco Use: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000.

2. Centers for Disease Control and Prevention. "Youth Risk Behavior Surveillance, United States, 1999" MMWR 2000 49:SS-5.

3. The University of Michigan. Cigarette Smoking Among American Teens Continues Gradual Decline (press release). December 17, 1999.

4. U.S. Department of Health and Human Services. Healthy People 2010 (Conference edition, in Two Volumes) Washington, DC: January 2000.

Tobacco Taxation Fact Sheet

- Substantial scientific evidence shows that higher cigarette prices result in lower overall cigarette consumption. Most studies indicate that a 10% increase in price will reduce overall cigarette consumption by 3% to 5%.
- Youth, minorities, and low-income smokers are two to three times more likely to quit or smoke less than other smokers in response to price increases.
- Increases in cigarette excise taxes are an effective policy tool in deterring smoking initiation among youth, prompting smoking cessation among adults, and reducing the average cigarette consumption among continuing smokers.
- Despite the proven effects of increasing both the price of cigarettes and tobacco excise taxes, the average price and excise tax on cigarettes in the United States is well below those of most other industrialized nations.
- Higher cigarette prices will not simply reduce average cigarette consumption but also will reduce overall smoking prevalence. Higher prices will result in more smokers deciding to quit and fewer young people opting to begin smoking.
- Studies of smokeless tobacco products suggest that increasing their prices would reduce the prevalence of smokeless tobacco use as well.
- Taxes on smokeless tobacco products are much lower than taxes on cigarettes, particularly at the federal level. Research suggests that increases in cigarette excise taxes, while reducing cigarette smoking, may have contributed to greater use of smokeless tobacco products. Some public health advocates and others have therefore called for the equalization of taxes on tobacco.
- Healthy People 2010 calls for state and federal taxes to increase to an average of $2.00 for both cigarettes and smokeless tobacco products by the year 2010.
- The importance of tobacco to the U.S. economy has been overstated. Judicious policies combined with higher tobacco taxes and stronger prevention policies can help foster economic diversification in tobacco-producing areas.

Global Cigarette Prices and Taxes in U.S. Dollars, 1999

Country	Tax as % of Price	Tax	Price
UK	86%	5.64	6.56
Denmark	82%	4.47	5.47
Portugal	80%	1.88	2.37
Finland	76%	3.82	5.02
France	76%	3.03	4.01
Canada[1]	75%	3.35	4.48
Belgium	75%	2.65	3.55
Italy	75%	1.94	2.60
Austria	74%	2.33	3.15
Greece	73%	1.75	2.41
Spain	73%	1.19	1.63
Netherlands	72%	2.37	3.29
Germany	71%	2.58	3.65
Sweden	70%	3.70	5.27
Ireland	60%	3.26	5.44
Canada[2]	55%	1.41	2.55
US[3]	41%	1.92	4.65
US[4]	11%	0.34	3.04

1: (Highest-New Foundland)
2: (Lowest-Ontario)
3: (Highest-Alaska)
4: (Lowest-Kentucky)

Source: Non-smokers' Rights Association web site at *http://www.nsra-*

Warning Label Fact Sheet

MINIMAL CLINICAL INTERVENTIONS

- Since the release of the first Surgeon General's report on smoking and health in the United States in 1964, about 10 million people have died from smoking-related diseases in the United States — heart disease, lung cancer, emphysema, and other respiratory diseases.[1]

- If current smoking patterns continue, an estimated 25 million Americans will die prematurely from a smoking-related illness, including an estimated 5 million people who are now children and adolescents under the age of 18 years.[1]

- The Federal Cigarette Labeling and Advertising Act of 1965 (Public Law 89-92) required that the warning "Caution: Cigarette Smoking May Be Hazardous to Your Health" be placed in small print on one of the side panels of each cigarette package. The act prohibited additional labeling requirements at the federal, state, or local levels.[2]

- In June 1967 the Federal Trade Commission (FTC) issued its first report to Congress recommending that the warning label be changed to "Warning: Cigarette Smoking Is Dangerous to Health and May Cause Death from Cancer and Other Diseases." [2]

- In 1969 Congress passed the Public Health Cigarette Smoking Act (Public Law 91-222), which prohibited cigarette advertising on television and radio and required that each cigarette package contain the label "Warning: The Surgeon General Has Determined That Cigarette Smoking Is Dangerous to Your Health." [2]

- In 1981 the FTC issued a report to Congress that concluded health warning labels had little effect on public knowledge and attitudes about smoking. As a result of this report, Congress enacted the Comprehensive Smoking Education Act of 1984 (Public Law 98-474), which required four specific health warnings on all cigarette packages and advertisements:

  - SURGEON GENERAL'S WARNING: Smoking Causes Lung Cancer, Heart Disease, Emphysema, and May Complicate Pregnancy.

  - SURGEON GENERAL'S WARNING: Quitting Smoking Now Greatly Reduces Serious Risks to Your Health.

  - SURGEON GENERAL'S WARNING: Smoking by Pregnant Women May Result in Fetal Injury, Premature Birth, and Low Birth Weight.

  - SURGEON GENERAL'S WARNING: Cigarette Smoke Contains Carbon Monoxide.[2]

- By the mid-1980s scientific evidence revealed that smokeless tobacco use causes oral cancer, nicotine addiction, and other health problems. The Comprehensive Smokeless Tobacco Health Education Act of 1986 (Public Law 99-252) required three rotating warning labels on smokeless tobacco packaging and advertisements:

  WARNING: This product may cause mouth cancer.

  WARNING: This product may cause gum disease and tooth loss.

  WARNING: This product is not a safe alternative to cigarettes.[2,4]

- Warning labels that appear on smokeless tobacco products in the United States are weaker, less informative, and less obvious labels used on the products than they are in some countries. The FTC is reviewing public comments on the effectiveness of the existing warning labels.[3]

- Warning labels on cigarette packages in the United States are weaker and less prominent than those of many other countries.[2]

- The Australian warning method uses six rotating messages covering 25% of the front of the cigarette package. One side panel is entirely given to the labeling of dangerous constituents. The government also requires that 33% of the back panel include the same message and an elaboration of that message.[2]

- The Canadian government soon will require tobacco manufacturers to display health messages and graphics along with information about smoking-related diseases and quit methods on all tobacco product packaging. These messages will occupy 50% of the front and back panels of the cigarette package, and additional information will be included inside. One side of the panel is given to the labeling of dangerous ingredients.[4]

- There is clear scientific evidence that cigar smoking represents a significant health risk and is not a safe alternative to cigarette smoking. Cigar use has been linked to oral, esophageal, laryngeal, and lung cancer. Regular cigar smokers who inhale, particularly those who smoke several cigars per day, have an increased risk for coronary heart disease and chronic obstructive pulmonary disease.[5]

- On June 26, 2000, the FTC announced a settlement with seven of the largest U.S. cigar companies requiring health warnings on cigar products. Health warnings must appear on the principal display panel to ensure warnings are easily seen. Each of the five required warnings must be displayed an equal number of times. The agreement also calls for warnings to be placed on various types of advertising, such as magazines and other periodicals, point-of-purchase displays, and catalogues.

- Every cigar package and advertisement will require the following warnings on a rotating basis:

  SURGEON GENERAL'S WARNING: Cigar Smoking Can Cause Cancers Of The Mouth And Throat, Even If You Do Not Inhale.

  SURGEON GENERAL'S WARNING: Cigar Smoking Can Cause Lung Cancer And Heart Disease.

  SURGEON GENERAL'S WARNING: Tobacco Use Increases The Risk of Infertility, Stillbirth And Low Birth Weight.

  SURGEON GENERAL'S WARNING: Cigars Are Not A Safe Alternative To Cigarettes.

  SURGEON GENERAL'S WARNING: Tobacco Smoke Increases The Risk Of Lung Cancer And Heart Disease, Even In Nonsmokers.[6]

REFERENCES

1. Centers for Disease Control and Prevention. Smoking-Atttributable Mortality and Years of Potential Life Lost–United States, 1984. MMWR 1997 46: 444-51.

2. U.S. Department of Health and Human Services. Reducing Tobacco Use: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000.

3. Centers for Disease Control and Prevention. Federal Trade Commission Request for Comments Concerning Regulations Implementing the Comprehensive Smokeless Tobacco Health Education Act of 1986. (Internet link) http://www.cdc.gov/tobacco/federal_register.htm Accessed [March 7, 2000].

4. Health Canada New Cigarette labeling Measures. http://www.tobaccolaw.org/Documents.

5. National Cancer Institute. Cigars Health Effects and Trends. Smoking and Tobacco Control Monograph No. 9. Bethesda (MD): U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Cancer Institute. NIH Publication No. 98-4302, 1998.

6. Federal Trade Commission. FTC Announces Settlements Requiring Disclosure of Cigar Health Risks: Landmark Agreements Require Strong Warnings on Both Packaging and Advertisements. (press release). June 26, 2000.