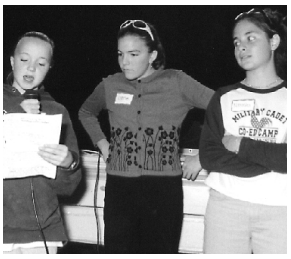
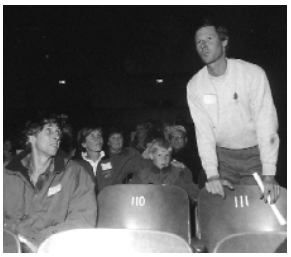
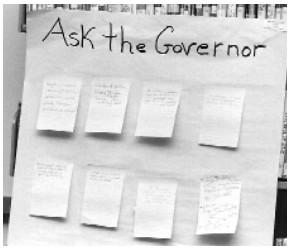
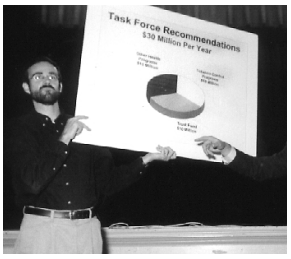
Blueprint for a Tobacco-Free Vermont





FINAL REPORT

The Tobacco Task Force

NOVEMBER 15, 1999

Blueprint for a Tobacco-Free Vermont

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For Task Force Reports write to:
Vermont Legislative Council
115 State Street, Drawer 33
Montpelier, VT 05633-5301
or
call: 1-800-322-5616
e-mail: **tobacco@leg.state.vt.us**
website: **www.leg.state.vt.us/tobacco**

Blueprint for a Tobacco-Free Vermont:
To the Governor and Vermont State Legislature

TOBACCO USE HAS TAKEN A TERRIBLE TOLL ON VERMONTERS:

• One of every three long-term users of tobacco will die from a disease related to their tobacco use;

• Tobacco use kills nearly 1,000 Vermonters every year;

• 22 percent of Vermont adults and 36 percent of Vermont youth smoke;

• The tobacco industry spends an estimated $13 million per year in Vermont in advertising and promotions to hook youth, the next generation of smokers.

• Tobacco-related health costs are over $200 million annually in Vermont. This figure will double in 10 years, if smoking rates do not change.

For years, the tobacco industry has skillfully deflected and avoided federal, state, and local regulatory efforts and promoted tobacco use by spending over $5 billion per year nationally on lobbying, advertising, and promotions. States, such as Vermont, have simply never had the budget or resources to fight back with comprehensive, long-term prevention and cessation programs.

All this changed in November 1998, when the tobacco companies agreed to settle a multi-billion dollar lawsuit brought by 46 states. Under the Master Settlement Agreement, Vermont is scheduled to receive payments in perpetuity. The state will receive approximately $30 million per year over the next 25 years.

Last spring, the Legislature and the Governor appointed the Tobacco Control, Prevention, and Cessation Task Force and charged it with developing a comprehensive plan by November 15 for the use of the settlement payments.

Task force members met and heard from national experts on tobacco prevention, cessation, and control programs throughout the summer. In the fall, during seven public forums including one youth forum, the Task Force heard the ideas of hundreds of Vermonters on how to use the tobacco funds.

Vermonters overwhelmingly told the Task Force to invest the money in comprehensive statewide tobacco prevention and cessation programs.

Vermont has been a national leader in anti-tobacco and clean air legislation. The Task Force recommendation to devote settlement funds to tobacco prevention and cessation programs, and to tobacco-related health expenses would continue Vermont's leadership role and create one of the most comprehensive health promotion efforts in the country.

Comprehensive, well-funded, sustained programs will substantially reduce smoking and other tobacco use and save thousands of Vermont lives and millions of taxpayer dollars in future healthcare costs.

The following sections will explain why the Task Force believes so strongly in investing the tobacco settlement on tobacco and health-related programs.

Section 1: Tobacco Use in Vermont: Costs and Consequences. There is both good news and bad news in the figures on adult and youth smoking in Vermont. This section outlines where the state stands today.

Section 2: What Works in Tobacco Prevention and Cessation Programs. For the past 30 years, researchers have been studying what works and doesn't work in these programs. This section contains highlights of their research.

Section 3: The Task Force Plan. The task force supports splitting the annual settlement into three mutually supportive components: a statewide Comprehensive Tobacco Prevention and Cessation Program; a Tobacco Trust Fund to support programs regardless of industry payments; and Support for Other Tobacco-Related Health Programs.

In addition, the Task Force strongly believes that an independent administrative board, consisting of members from the public and private sectors, is the most effective way to give all Vermonters a voice and to ensure that tobacco settlement money is used for tobacco-related programs.

Section 4: Task Force Meetings and Forums. The Task Force met over a dozen times through the summer and fall to hear testimony from state and national experts on tobacco use. The Task Force also held seven public forums in October. This section details what members learned.

Over the past five months, the Task Force has tried to be good listeners. Members have heard from national experts and from Vermonters of all walks of life. Everyone had the same goal: Reduce tobacco use and improve the health of all Vermonters.

The Task Force shares that goal and offers this plan as a first step.

Ann Seibert and Helen Riehle,
Chair and Vice-chair, Tobacco Task Force

Blueprint for a Tobacco-Free Vermont: Executive Summary

The Task Force was appointed by the Governor and the Legislature last spring to develop a spending plan for the estimated $30 million a year Vermont will receive from the tobacco industry.

The Centers for Disease Control and Prevention — the country's leading authority on reducing tobacco death and disease — has recommended spending from $7.9 million to $15.9 million annually in Vermont. The Task Force's plan to spend about $10 million per year on a comprehensive prevention and cessation program is at the lower end of the CDC's recommendations.

The CDC's recommendation is designed specifically for Vermont. Massachusetts, considered to be one of the most successful states in reducing adult and youth consumption, is about to increase its total investment in its tobacco program to $14.30 per capita. Because Vermont is such a small rural state and cannot benefit from the economies of scale enjoyed by Massachusetts and other larger states, the CDC recommends a higher level of per capita investment for Vermont.

The Task Force plan has two parts: Part One splits the tobacco fund settlement equally among three programs; Part Two recommends the creation of an independent board to administer the tobacco programs

Part One

1. Comprehensive Prevention and Cessation Program: 1/3, approximately $8 to $10 million.

Reducing smoking rates requires well-funded, long-term and comprehensive programs free of tobacco and political influence. The following programs would be funded:

- Public Education
- Counter-advertising to Tobacco Marketing
- Community-based Programs
- Treatment of Tobacco Addiction
- School-based Programs
- Enforcement of Tobacco Laws
- Monitoring and Evaluation

Task Force Members

Rep. Ann Seibert *(Norwich)*
Sen. Helen Riehle *(Chittenden County)*
Rep. Karen Kitzmiller *(Montpelier)*
Sen. Elizabeth Ready *(Addison County)*
William Sorrell, *Attorney General*
Jan Carney, M.D., *Commissioner of Health*
Marc Hull, *Commissioner of Education*
Kay Perkins, *low-income advocate*
Philene Taormina, *public health advocate*
Brian Flynn, *smoking prevention expert*
John Hughes, M.D., *smoking cessation expert*

2. Permanent Tobacco Control Trust Fund: 1/3, approximately $8 to $10 million.

By investing $10 million from the tobacco funds each year in a special trust fund, Vermont can use the interest to pay for anti-tobacco programs well into the future. This investment in Vermont's future becomes the gift that keeps on giving.

3. Support of Other Health Programs: 1/3, approximately $8 to $10 million.

Vermont spends an estimated $30 million a year for state-funded health insurance programs for tobacco-related health illnesses. The Task Force supports spending $10 million to support the cost of tobacco-related health expenses.

Part Two

An Independent Administration

The Task Force supports the creation of an independent board to administer Vermont's tobacco prevention program. This board would include a cross-section of Vermonters concerned about tobacco use in Vermont. The Task Force strongly believes that an independent board, consisting of members of the public and private sectors, is the most effective way to ensure:

- Program investments are appropriately monitored and evaluated.
- Investment decisions are quickly modified or altered in the event that grants are not producing appropriate results within reasonable time frames.
- Creative partnerships with other states, federal government and the business community are maximized.
- State expenditures are leveraged to the greatest extent possible through grant monies from federal and private sources.
- All critical sectors of Vermont have a voice in the development of the tobacco prevention and cessation program.

For More Information

Call Legislative Council at 1-800-322-5616 for any Task Force Report or e-mail to tobacco@leg.state.vt.us or check www.leg.state.vt.us/tobacco. ■

Tobacco Use in Vermont: Section 1: Costs and Consequences

There is both good and bad news in the statistics on adult and youth smoking in Vermont. Among adults, the good news is that smoking use has dropped from its high point after World War II when slightly more than 50 percent of men smoked. Today, 22 percent of Vermont adults smoke.

The bad news is that this decline in smoking rates has leveled off and women, who smoked at half the rate of men 50 years ago, now smoke almost as much as men.

Further bad news is that the public's estimates of adult smoking are twice the actual smoking rates, testament to the tobacco companies' ability to create the perception that smoking is the norm not the exception.

The good news is that smoking cessation programs, with new effective medications, increase smokers' chances of overcoming their addiction.

The bad news is that cessation programs are now dealing with "hard core" smokers and only about 5 to 10 percent of these smokers are successful in each attempt to quit. After multiple attempts about half the smokers who try to quit are able to quit.

The good news remains that if youth don't begin smoking before age 18, there is only a 10 percent chance that they will begin to smoke as adults.

The bad news is that youth smoking levels that had been falling through the 1980s began rising again in the 1990s, largely due to the tobacco companies' skillful marketing and promotions. Today about 36 percent of Vermont youth in 8th through 12th grade smoke, slightly above the national average.

This section begins with a brief discussion of the powerful addictiveness of nicotine.

The following sections will examine this good news-bad news scenario by looking at the impact of smoking in Vermont on youth, women, the low income, and the elderly.

Nicotine: A Seductive, Deadly Drug

Nicotine dependency through cigarette smoking is the most common form of drug addiction and the most deadly —nicotine addiction causes more death and disease than all other addictions combined.

Of the thousands of chemicals and toxins in cigarettes, nicotine is in many ways the most harmful.

Nicotine tricks the user because it is not an intoxicating or overpowering drug. Cocaine stimulates the user. Alcohol sedates the user. Nicotine both stimulates and sedates the user without any apparent immediate side affects.

Nicotine can control anxiety and hunger, aid concentration, and stabilize moods. And it can deliver these "rewards" almost immediately; each puff delivers nicotine to your brain in less than 10 seconds. The brain feels the effects of nicotine faster than it feels the effects of a shot of heroin in the arm.

Some of the nicotine goes to other parts of the body as well. If a woman is pregnant, this burst of nicotine also reaches the fetus through connecting blood vessels.

Someone taking 10 puffs on each of 20 cigarettes per day for 20 years is thus "rewarded" 1.5 million times. A lifetime of smoking creates a powerful drug dependence that is extremely difficult to break for adults and youths.

While nicotine is extremely addictive, people smoke for other reasons as well. Smokers get hooked on the taste, smell, and feel of cigarettes. Many link smoking with other activities such as having a cup of coffee after dinner or when they are relaxing at home. For others, it is an activity closely related to social events such as parties and get-togethers. The combination of nicotine addiction and these mental links make smoking a tough habit to break.

Smoking can be an "upper" or a "downer" drug for people. Nicotine's impact depends on several things such as the amount of nicotine in the body, the time passed since the last cigarette, stress level, and even time of day. Early in the day it tends to act as a stimulant while later in the day it acts more like a sedative and helps people relax. This dual property makes it appealing all the time to smokers.

Not everyone likes cigarettes, at least at first. Nicotine often makes people feel sick to their stomach and dizzy during the first few cigarettes. As more cigarettes are smoked, however, the unpleasant side effects fade and smokers get used to nicotine's stimulant effects.

Soon smokers find themselves needing to smoke more cigarettes. Eventually smokers find the number of cigarettes that delivers the dosage that physically satisfies them. At that point, the smoker is physically addicted and will only feel comfortable when nicotine is in his or her system.

Seventy percent of Vermont youth have tried cigarettes at least once, believing that unlike heroin or cocaine they

"Smoking kills nearly 1,000 Vermonters each year, more than alcohol, AIDS, car crashes, illegal drugs, murders, smoking-related fires, and suicides combined."

won't get addicted. But about 14 percent end up smoking on a daily basis, a far greater percentage than the percentage of people who become addicted to marijuana and alcohol.

Stopping is extremely difficult. The success rate for smokers is about 5 to 10 percent for each attempt, about the same success rate as those trying to quit heroin and cocaine. About half the smokers who attempt to quit are eventually able to stop smoking.

Sources: Surgeon General's Report; Vermont Department of Health; John Hughes, M.D., College of Medicine University of Vermont

Health Effects and Medical Costs

The consequences for Vermonters who start and can't stop smoking are breathtaking.

• Twenty percent of all deaths in Vermont are due to smoking; smokers have a 45 percent probability of dying from a tobacco-related disease. What other "regular behavior" has a 1 in 2 chance of killing you?

• Smoking kills nearly 1,000 Vermonters each year, more than alcohol, AIDS, car crashes, illegal drugs, murders, smoking-related fires, and suicides combined.

• 12,000 Vermont kids now under age 18 will die from smoking if current trends continue.

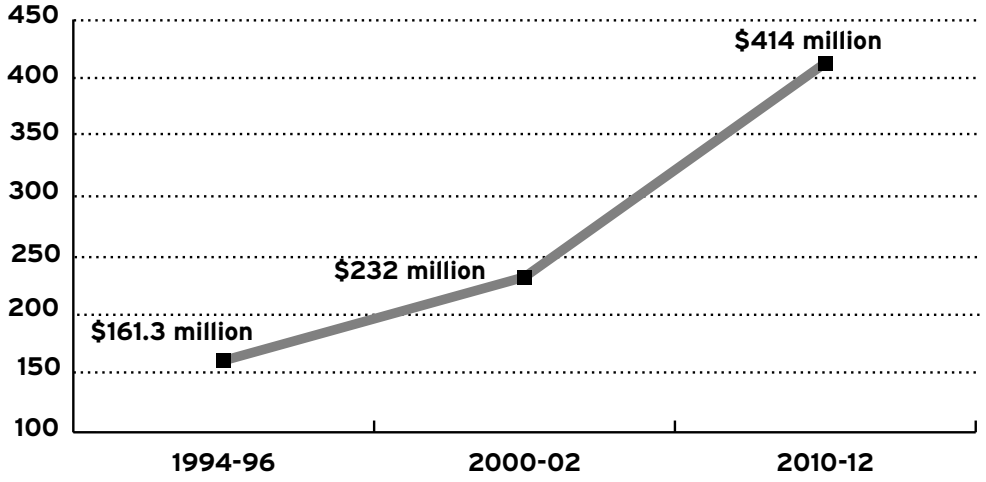
• Studies rank environmental tobacco smoke (ETS), also known as secondhand smoke or passive smoking, as the third leading cause of preventable death in the United States, after active smoking and alcohol use, with an estimated 53,000 deaths annually. About half of these deaths occur from exposure in the workplace.

The costs of tobacco use are also staggering.

A 1993 national study by the School of Social Welfare at the University of California at Berkeley found that 6.6 percent to 14.1 percent of a state's medical expenses resulted

Smoking Attributable Costs: If current rates continue

Source: Vermont Department of Health Status Report: 1998



A 1993 national study estimated Vermont's tobacco-related expenses at 12.8 percent of all medical expenses, slightly higher than the national average of 11.8 percent.

from tobacco use. The study estimated Vermont's tobacco-related expenses at 12.8 percent of all medical expenses, slightly higher than the national average of 11.8 percent.

• Annual health care expenditures in Vermont directly related to tobacco use: $200 million. This figure will double in 10 years if the rate of smoking remains unchanged.

• Residents' state and federal tax burden caused by tobacco-related health costs: $70 million

• State Medicaid payments directly related to tobacco use: $29 million

• Additional annual expenditures in Vermont for babies' health problems caused by mothers smoking or being exposed to second-hand smoke during pregnancy: $3 to $10 million

Additional health care expenditures caused by tobacco include the costs related to direct exposure to secondhand smoke, smoking-caused fires, and smokeless tobacco use. Although these additional health expenditures certainly total in the tens of millions of dollars in Vermont, and increase Vermont's Medicaid burden, there are no good state estimates currently available.

• Other non-health costs caused by tobacco use include direct residential and commercial property losses from fires caused by cigarettes or cigars (more than $500 million nationwide); work productivity losses from work absences, on-the-job performance declines, and early termination of employment caused by tobacco-related health problems ($40-plus billion per year nationwide); and the costs of the extra cleaning and maintenance made necessary by tobacco smoke, smokeless tobacco spit, and tobacco-related litter (over $4 billion per year nationwide for commercial establishments alone).

Good state-specific estimates of these non-health costs from tobacco are not available, but Vermont's pro-rata share, based on its population, is at least $80 million per year.

Three-Year Average Smoking Attributable Death and Direct Health Care Costs by Geographic Regions

Source: The Impact of Cigarette Smoking in Vermont, 1990-1992

County	Deaths	Cost (*millions*)
Addison	40	$2.2
Bennington	74	$3.1
Northeast Kingdom	111	$4.4
Chittenden	152	$9.1
Franklin/Grand Isle	75	$3.5
Lamoille	32	$1.4
Orange	34	$2.0
Rutland	116	$4.7
Washington	78	$4.1
Windham	69	$3.2
Windsor	100	$4.3

"Today's teenager is tomorrow's potential regular customer, and the overwhelming majority of smokers first begin to smoke while still in their teens… The smoking patterns of teenagers are particularly important to Philip Morris."

– 1981 Philip Morris internal document

Tobacco Use

Youth and Young Adults

There are five stages of smoking among youth and adolescents: **Preparation** when youth are influenced by advertising perceptions about the number of people who smoke, and by role models; **Trying** when youth are influenced by peers and the availability of cigarettes and smoke their first few cigarettes; **Experimentation** when youth smoke repeatedly but irregularly and are influenced by peers and social situations that support smoking; **Regular Use** when adolescents smoke weekly and face few restrictions on smoking in school, home, and community; **Addiction** when youth develop a physiological need for nicotine.

• Vermont measures frequent use as smoking 20 or more days each month. Youth face extensive restrictions on smoking in schools and some community restrictions, *i.e.*, it is illegal for youth to possess tobacco products, and compliance checks make it difficult for youth to purchase.

• Early adolescence, grades 6 to 10, is the highest risk period for smoking trial and experimentation.

• The cigar fad has reached kids nationally. In 1997, 31 percent of boys and 11 percent of girls in grades 9-12 reported smoking a cigar at least once in the last 30 days.

• Use of starter products, such as candy cigarettes, and low-priced foreign cigarettes are increasing nationally. This is not yet a problem in Vermont.

• Adolescents consistently overestimate the prevalence of smoking among their peers and adults.

• Smoking as few as five cigarettes per day can reduce the lung function growth of both boys and girls during adolescence, with teenage girls being particularly vulnerable. By age 18, teenage girls who do not take up smoking are likely to reach and maintain a higher maximal lung function than their smoking counterparts.

• Three-quarters of young people who are daily cigarette smokers or smokeless tobacco users report that they continue to use tobacco because they find it hard to quit.

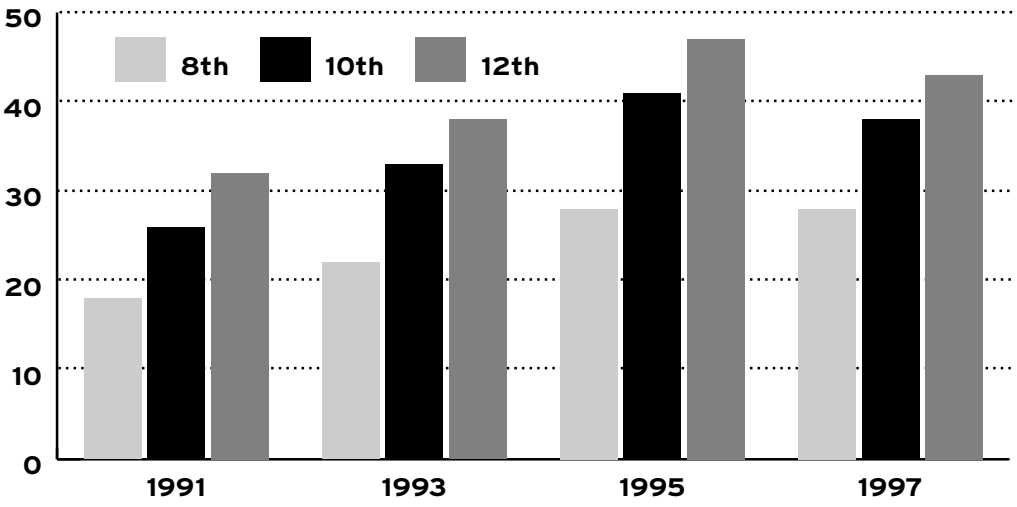
• More than 90 percent of young people who use tobacco daily experience at least one symptom of nicotine withdrawal — difficulty concentrating, irritability, cigarette cravings — when they tried to quit.

Tobacco companies spend over $5 billion each year (nearly $14 million every day) nationally promoting their products in order to replace the thousands of customers who either die or quit using these products each year.

Tobacco industry documents, research on the effect of marketing to kids, and the opinions of advertising experts reveal the intent and the success of the industry's efforts to attract new smokers from the ranks of children. Numerous tobacco industry documents make clear that the industry

Smoking Among Vermont Adolescents 1991-1997: Cigarette Smoking during the past 30 days

Vermont Department of Health Status Report: 1998



"Marketing cigarettes as 'slims' or 'thins' plays into social pressures on young women to control their weight, manage stress, and appear grown-up."

has viewed kids as young as 13 years of age as a key market, studied the smoking habits of these kids, and developed products and marketing campaigns aimed at them:

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

• 86 percent of kids who smoke prefer Marlboro, Camel, and Newport–the three most heavily advertised brands; only about one-third of adult smokers choose these brands. Marlboro, the most heavily advertised brand, constitutes almost 60 percent of the youth market but only about 25 percent of the adult market.

• 30 percent of kids (12 to 17 years old), both smokers and nonsmokers, own at least one tobacco promotional item, such as T-shirts, backpacks, and CD players.

• The development and marketing of "starter products" with such features as pouches and cherry flavoring have resulted in smokeless tobacco going from a product used primarily by older men to one for which young men comprise the largest portion of the market. Twelve percent of Vermont high school boys are current smokeless tobacco users.

Women

While smoking among both men and women has decreased over the years, women, who once smoked at half the rate of men, are now almost as likely to smoke. Recent increases in smoking by high school girls suggest that the problem may well get worse in the future.

Tobacco use among women should be considered separately because women respond differently to cultural and social influences and to tobacco marketing and promotion. They also have different consumption patterns. Finally, smoking is a significant risk to the health of mother and child during pregnancy.

• As with men, smoking by women is strongly linked to heart disease and lung cancer. Smoking also increases the risk of cervical cancer and osteoporosis.

• Women who smoke have a 50 percent higher risk of a heart attack than male smokers.

• In the 1980s, lung cancer overtook breast cancer as the leading cancer killer of women.

• Cigarette smoking accounts for 43 percent of lung cancers in women. Lung cancer incidence and death rates are similar for men and women. However, the incidence of lung cancer is rising nine times faster in women than men.

• The reproductive side effects of smoking cigarettes include spontaneous abortions, stillbirths, premature menopause, infertility, and low birthweight. Nevertheless, an estimated 17.5 percent of pregnant women smoke in Vermont, compared to a national average of 14 percent.

• Women have a more difficult time quitting smoking than men. They have lower cessation rates, and girls and women aged 12-24 are more likely to report being unable to cut down on smoking than men and boys the same age.

• Girls and women are significantly more likely than boys to report feeling dependent on cigarettes, and are more likely to report feeling sad, blue, or depressed during quit attempts.

• In the United States, sudden infant death syndrome (SIDS), the major cause of death in infants between the ages of 1 month and 1 year, is strongly linked with maternal smoking. This risk is independent of other known risk factors for SIDS, including low birthweight and low gestational age, both of which are specifically associated with smoking during pregnancy.

Marketing to Women

Cigarette companies first began targeting women in the 1920s to recruit female smokers, equating smoking with freedom and emancipation.

• The National Health Interview Survey shows an abrupt increase in smoking initiation among girls around 1967—the same time advertisements for brands specifically targeted at women entered the market.

• Six years after the introduction of Virginia Slims and other female brands, the rate of smoking initiation of 12-year-old girls had increased by 110 percent. Increases among other teenage girls were also substantial.

• Tobacco companies continue to target young women by offering product tie-ins, such as Philip Morris' "Woman Thing Music," a series of promotional pop concerts featuring young female artists and compact discs available only with the purchase of cigarettes; and "Virginia Slims Wear," a clothing line targeted at young women and available through catalogues with Virginia Slims proof of purchase coupons.

• Marketing cigarettes as "slims" or "thins" plays into social pressures on young women to control their weight, manage stress, and appear grown-up. One study found that girls who had recently dieted or were concerned about their weight were more than twice as likely to be current smokers as those who had not dieted or were not concerned about their weight.

Sources: National Campaign for Tobacco-Free Kids

Low-Income Smokers

• Low-income smokers are 27-33 percent less likely to quit each year than non-poor smokers. This rate partly results from their lack of transportation and access to treatment.

• When low-income smokers are given free patch therapy they do nearly as well as other smokers.

• 63 percent of unemployed adults, from 18 to 24, smoke.

• The majority of studies show, despite tobacco industry claims, that increased taxes decrease smoking more among low-income than wealthier smokers.

Source: John Hughes, M.D.

The Elderly

Today's generation of older Americans, people who are now 50 and over, had smoking rates among the highest of any generation. In the mid-1960s, about 54 percent of adult males smoked and another 21 percent were former smokers; over 34 percent of adult females were smokers and another 8 percent were former smokers. Today's epidemic of smoking-related deaths results from these high smoking rates.

The good news is that research shows that stopping smoking results in improvement in health status at any age, including persons aged 65 and over. Some health benefits are almost immediate, and the longer people refrain from smoking, the more their health improves.

The bad news is that 94 percent of the over 416,000 smoking-related deaths annually in this country. are to persons aged 50 and over. Seventy percent are to persons aged 65 and over.

• One in three smokers die prematurely in the U.S., losing an average of 12 to 15 years of life versus normal life expectancy, thereby reducing retirement years for most of these people.

• 8.3 percent of Vermonters 65 and over smoke. 20.8 percent of Vermonters 25 to 64 smoke.

• Nationally about 13 percent of persons aged 65 and over are smokers—about 4 million persons. About 26 percent of persons aged 50 to 64 are smokers—about 9 million persons. Altogether over 13 million Americans aged 50 and over are currently smokers, accounting for about 27 percent of all adult smokers in the U.S.

• Of the approximately 3 million pipe smokers in the U.S., over half are over the age of 46.

• All the major causes of death among the elderly are associated with smoking or Environmental Tobacco Smoke (ETS) — cancer, heart disease, and stroke. And, each of these diseases generally is associated with months and years of disabling pain and suffering.

• Smoking is the number one cause of fires that kill older persons. Tobacco-related fires claimed nearly 1,400 lives in 1995.

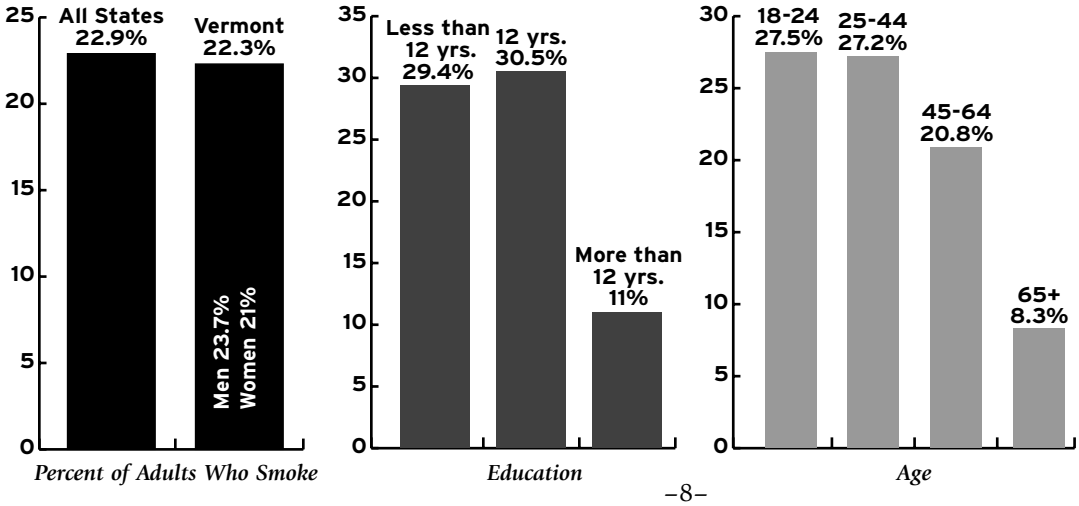
• Smoking, particularly when combined with heavy alcohol consumption, is the primary risk factor for approximately 75 percent of oral cancers in the U.S. In 1998, about 30,000 Americans will be diagnosed with oral and throat cancer; about 8,000 deaths will result, of which 5,200 will be men and 2,800 women.

• Recent research has indicated that smoking use is related to a number of other health problems/diseases that are generally associated with aging, including hearing loss, dementia and Alzheimer's. ■

Source: The Center for Social Gerontology

Cigarette Smoking by Vermont Adults 18 and Older in 1998

Source: Vermont Department of Health



Section 2: What Works in Prevention and Cessation

Vermont can substantially and permanently reduce smoking and other tobacco use if it establishes a well-funded, sustained, and comprehensive tobacco prevention and cessation program. Vermont has an historic opportunity to reduce tobacco use, but the state must invest in proven programs if it is to reduce tobacco use.

The following sections will discuss the guiding principles and elements of successful programs.

Two Vermont experts and members of the Tobacco Control Task Force, Brian Flynn and John Hughes, M.D., at the College of Medicine of the University of Vermont, present findings from their tobacco prevention and cessation work in Vermont and around the country. More specifically, the Vermont Department of Health has drawn up program guidelines to prevent and reduce school smoking. Highlights of that program follow.

And finally this section will briefly examine the results of six states, California, Massachusetts, Florida, Oregon, Mississippi and Minnesota, all leaders in anti-smoking programs.

Elements of a Comprehensive Program

Experience shows that statewide programs to reduce tobacco use are far more effective when they coordinate the following elements.

Public Education: Research has demonstrated that tobacco industry marketing increases the number of kids who try smoking and become regular smokers. Not surprisingly, one of the best ways to reduce the power of tobacco marketing is an intense campaign to counter these pro-smoking messages.

These efforts must include multiple paid media (TV, radio, print, etc.), public relations, special events and promotions, and other efforts. Counter-marketing efforts should target both youth and adults with prevention and cessation messages. Any restrictions placed on the strategies used in these efforts will only hamper effectiveness.

Community-Based Programs: Programs like The National Cancer Institute's ASSIST (American Stop Smoking Intervention Study) Project have demonstrated that community-based programs reduce tobacco use. Because community involvement is essential to reducing tobacco use, a portion of the tobacco control funding should be provided to local government entities, community organizations, local businesses, and other community partners.

These groups can effectively engage in tobacco prevention activities right where people live and work, including direct counseling for prevention and cessation, youth tobacco education programs, interventions for special populations, worksite programs, training for health professionals, and enforcement of local youth access ordinances. Criteria for eligibility and accountability must be established to ensure that community-directed funds are spent on the most effective efforts.

School-Based Programs: School-based programs offer a useful way to prevent and reduce tobacco use among kids, especially when based on the CDC's Guidelines for School Health Programs to Prevent Tobacco Use and Addiction. To operate most effectively, school-based programs must include curricula that have been shown to be effective, as well as tobacco-free policies, training for teachers, programs for parents, and cessation services. Students must learn not only the dangers of tobacco use, but also life skills, refusal skills, and media literacy in order to resist the influence of peers and tobacco marketers. It is also critical that the school programs be integrated with other community-based programs and with counter-marketing efforts.

Treatment of Tobacco Addiction (Cessation): A comprehensive tobacco control program should not only encourage smokers to quit but also help them do it. In fact, most smokers want to quit but have a very difficult time because nicotine is so powerfully addictive. To help these smokers, cessation products and services should be made more readily available and more affordable. Moreover, treatment programs are most effective when they utilize multiple interventions, including pharmacological treatments, clinician-provided social support, and skills training.

Cessation services can be provided through primary health care providers, schools, government agencies, community organizations, and telephone "quit lines." Staff training and technical assistance should be a part of all cessation services; and following the cessation guidelines from the Agency for Health Care Policy and Research will improve the effectiveness of any cessation efforts in clinical settings.

Enforcement: Rigorously enforcing laws prohibiting tobacco sales to youth and limiting exposure to second-hand smoke is an essential element of creating an environ-

Keys to Effective Evaluation

- Link measurable objectives to program activities
- Monitor program implementation
- Assess outcomes of programs
- Have realistic expectations

ment conducive to reducing tobacco use. These enforcement efforts should include hot lines for reporting violators, frequent compliance checks, penalties for violators, and compliance enhancing education.

Studies show that reducing youth access to tobacco products can reduce use and that establishing smoke-free workplaces, schools, and public areas can both reduce the amount people smoke and even prompt many smokers to quit. To increase tobacco control enforcement, funds must be provided to enforcement agencies to make sure other enforcement efforts are not compromised.

Other agencies and organizations should be supported to provide related educational efforts to raise awareness of the laws and their enforcement and to promote compliance.

Monitoring and Evaluation: Every element of a comprehensive tobacco control program should be rigorously evaluated throughout its existence. Programs should be based on available research and lessons learned from past efforts, and specifically designed to effectively serve their targeted audiences. Careful monitoring and evaluation and independent audits should be built into the programs to provide the data necessary for continual improvement.

Regular measurements of key outcomes should also be conducted to assess progress and to improve performance. Through this evaluation work, a state's tobacco initiative can be adjusted and improved to ensure that tobacco use declines as quickly as possible.

Results from Smoking Reduction Programs

• **Focused school programs prevent adolescent smoking.** The best school programs, acting alone, have reduced smoking prevalence in grade 12 by 20 percent.

Effective classroom programs can be delivered by teachers who have received curriculum training. Effective programs are based on a common core of objectives that reflect what we know about why young people start smoking. These programs are usually delivered between grades 6 and 9. More effective programs are relatively intensive, with up to 30 class sessions delivered over several school years.

• **Mass media messages prevent adolescent smoking**. Intensive media campaigns, combined with school programs, have reduced high school smoking prevalence by 35 percent.

Specially designed messages are placed on radio and television programs that adolescents frequently see or hear. These messages address factors, which are known to influence youths' decisions on smoking.

Such media campaigns take time — at least three years — before effects on smoking rates can be detected. Similar media campaigns for adult smokers have been included in comprehensive community smoking cessation programs.

• **Community tobacco education programs help prevent adolescent smoking.** When school smoking prevention programs are combined with community education programs, there have been reductions in adolescent smoking prevalence of 20 to 40 percent.

Two types of community tobacco education programs have reduced cigarette smoking among young people. The first type combines intensive community smoking cessation programs directed toward adults with a simultaneous school education program. The second type combines community education programs for parents and other citizens with educational programs in the schools. Both types were implemented for at least three years.

• **Enforcement strategies can reduce sales of cigarettes to underage persons.** Systematic community and merchant education combined with compliance checks can raise compliance rates above 80 percent.

These interventions are intended to encourage more active enforcement of laws restricting cigarette sales to minors by retail outlets. They most often include merchant education concerning state laws combined with compliance checks; community education programs also may be included.

Compliance checks are conducted by trained underage persons attempting to purchase cigarette from retail outlets selected on a systematic schedule.

Medications and Counseling Help Smokers Stop Success Rates Per Quit Attempt			
	No Advice	Brief Advice	Longer Counsel
No Meds	3%	11%	19%
Meds	10%	18%	30%

• **Health care providers increase their patients' quit rates.** Brief physician advice provided systematically can more than double the natural quit rate.

Health care providers see 70 percent of current adult smokers each year. But only 24 percent of primary care physicians, according to national figures, consistently provided specific strategies to quit smoking to their patients, according to national studies. About 44 percent of Vermont health care providers offer specific strategies to their patients to quit smoking. These visits are opportunities to motivate patients to quit and to provide them with resources to help them quit. The most effective interventions include repeated contacts with multiple providers.

• **Behavioral counseling or medications also help smokers quit.** Use of medications consistently increases quit rates. The efficacy of behavioral counseling increases with more contact.

Behavioral counseling encompasses both brief advice (3-10 minutes) and longer counseling (greater than 10 minutes) provided face-to-face, by telephone, or in a small group context. The focus is on providing support for quitting and on problem-solving barriers to smoking cessation.

Medications for smoking cessation include over-the-counter nicotine gum and nicotine patches and prescription nicotine nasal spray, nicotine inhaler, and bupropion.

Over 150 clinical trials indicate that these medications double quit rates and that none have significant harmful side-effects. Other treatments such as hypnosis, acupuncture, 12-step groups, and inpatient therapy have not been proven scientifically effective for smoking cessation.

• **Systems for implementing smoking cessation programs improve the interventions of health care providers.** Use of these systems markedly increases the number of patients attempting to quit and the quality of the interventions.

Physicians and other health care providers do not reliably perform the recommended cessation interventions because of lack of time, training, or resources and because they believe their interventions are ineffective. Some health care organizations have provided organized smoking cessation interventions to which physicians can refer patients for the time-consuming tasks of assistance and follow-up.

This can magnify the effects of a physician's brief advice to quit. However, to be fully effective the physician's office environment must be structured with systems to identify current smokers and to facilitate referral to appropriate programs.

Sources: Brian Flynn and John Hughes, M.D., College of Medicine, University of Vermont, and the Vermont Department of Health

What Works in Cessation Programs

Proven	**Unproven**
(For Most Smokers)	
Over-the-counter Medications	Hypnosis
Telephone Helplines	Acupuncture
Health Providers' Advice	Cigarette Filters
Media Motivation Campaigns	Injections
(For Seriously Addicted Smokers)	Herbal Treatments
Prescribed Medications	12-Step Therapy
Group and Individual Counseling	Homeopathic Treatments

• A comprehensive cessation program includes a media campaign that encourages smokers to try and quit; advice and support from health care providers; help paying for medications, such as nicotine patches which can cost $3 per day; free written material and helplines for most smokers; and clinics and other facilities for the small minority of very dependent smokers.

• Cessation provides immediate benefits: it improves the health of the smoker and cuts health care costs. With aggressive cessation programs, the state should see reductions in health care costs within five years. Prevention will not curb health care costs in the short-run as smoking-related diseases take years to develop.

• Heavily addicted smokers may try to quit half a dozen times or more over a period of years and need medications and counseling. About half of these smokers are eventually able to quit.

National guidelines support the use of medications with all smokers who are trying to quit. Effective medications include nicotine gum and patches, nasal sprays, inhalers, tablets, bupropion, and clonidine. These medications are safe and equally effective. Smokers should choose the medication they are comfortable with.

Tobacco Prevention Taboos

- Don't focus only on kids and lecture them.
- Don't position tobacco use as an adult habit.
- Don't send mixed messages.
- Don't conduct programs in isolation.

• Medications that contain nicotine are not harmful. Tar, carbon monoxide, and hundreds of toxins, not nicotine, produce most of the harmful effects of smoking. Long-term use of nicotine, outside of tobacco use, does not appear to be harmful. Current research indicates that nicotine medications that provide a slower, lower dose of nicotine are not addicting.

• Medications such as tranquilizers, Prozac, and stimulants don't work. Acupuncture, hypnosis, 12-step therapy, switching to low-tar cigarettes, and herbal treatments do not work.

• Health providers' advice and support motivate smokers to quit and can increase quit rates by 50 percent.

• Group behavior and support therapy can double quit rates. But only 10 percent or less of smokers are interested in these programs, which are often not covered by medical insurance. These programs are also often not available in rural areas and are infrequently offered in urban areas.

• About 10 times more people use medications than participate in behavior therapy.

• Some women, concerned about gaining weight, do not attempt to quit. However, medications can lessen the weight gain.

• Telephone helplines are an alternative to group therapy, especially in rural areas, and can increase success rates by about 25 percent.

• Smoking restrictions at worksites prompt many smokers to quit.

• Increasing taxes on cigarettes reduces smoking among adults and discourages youth from smoking. A 10 percent increase in cigarette price generally decreases adult smoking by about 4 percent and youth smoking by 7 percent.

• Smokers who quit will see an improved quality of life almost immediately. One's sense of smell and taste improves and the smoker's hacking cough disappears.

• Quitters also benefit in the long run with a reduced risk of lung cancer, heart diseases, strokes, and respiratory illnesses.

• After 10 years, smokers who quit have nearly the same risk of fatal heart diseases as non-smokers.

Source: John Hughes, M.D.

Youth Prevention Programs

In the early 1960 and 1970s, researchers believed that many young smokers simply did not understand the health hazards of smoking. If youth understood the dangers of smoking, be it through classroom lectures, pamphlets, films, or posters, they would not start.

Research has since found that public education on the consequences of smoking is important, but it is not sufficient to change young people's behavior.

Similarly, programs in the 1970s that concentrated on raising youth's self-esteem and changing negative attitudes about home, school, and community were no more effective, when used alone, than the education only approach.

Early programs often attempted to frighten adolescents about the long-term health risks in smoking. But research found that scare tactics based on long-term consequences do not alter the short-term behavior of adolescents.

Most successful programs that provide skills to resist social pressures to smoke share several major components:

• They correct the misperception that most adolescents smoke;

• They include training in resisting tobacco marketing and peer pressures;

• They provide training that increases the assertiveness, decision making and communication skills of young people.

School-based smoking-prevention programs should also incorporate the program into existing school curricula; introduce the program during the transition from elementary to junior or middle school; involve students in the presentation and delivery of the program; encourage parental involvement; and be socially and culturally acceptable to each community.

Parents are influential role models. Children of two smoking parents are twice as likely to smoke as children of non-smoking parents. If one parent smokes, young people are also more likely to smoke.

Smoking-cessation programs still tend to have low success rates. Recruiting and retaining adolescents in formal cessation programs is difficult.

Sources: Report of the Surgeon General, 1994; and Brian Flynn

Middle school children are the most vulnerable to pro-tobacco influences. The battle for the hearts and minds of our children will be fought and won with this age group.

School Guidelines

Since 1995, Vermont has prohibited anyone from using tobacco products, at any time, on school grounds.

Effective July 1, 1997, children under the age of 18 in Vermont cannot legally possess tobacco products. The fine for possession is $42.50. Youths under 16 cannot take the test for a driver's license if they have unpaid fines. Youths, ages 16 or 17, can have their driver's license suspended for up to 90 days if they do not pay their fine.

School boards are now required to adopt policies dealing with the possession and use of tobacco products by students while on school grounds or under the supervision of school staff.

Schools have a key role in preventing tobacco use and intervening when students do smoke. But a successful anti-tobacco program also requires the involvement of parents, peers, the media, and others.

The Four Essentials for Every School

1. A Written School Board Tobacco Policy

A written policy is the road map for the development of successful tobacco prevention strategies and programs. The development of a policy enables school board members and school officials to open a dialogue with students, parents and the community on the addictiveness of nicotine, the health consequences of tobacco use, and the reasons why tobacco use is legally restricted to those 18 and older.

2. A Comprehensive, Research-based Health Education Curriculum

Act 51 requires each school district to provide health education instruction, including instruction on drugs, alcohol, and tobacco, to students. Research shows that middle school children are the most vulnerable to pro-tobacco influences. The battle for the hearts and minds of our children will be fought and won with this age group. The Vermont Department of Health's Office of Health Promotion and Vermont Kids Against Tobacco (VKAT) can provide school activities to assist in preventing tobacco use. The Vermont Departments of Health and Education can review curricula and recommend effective programs.

3. Appropriately Trained School Professionals and Ongoing Support

A research-based curriculum is essential, but the key to a successful program is personnel trained to use that curriculum. Supplementary material and ongoing educational training are needed to support staff and help them stay current.

4. Support Services and Referral for Treatment

Prevention should be the primary focus, but some children are already addicted to tobacco and need additional help.

Source: Vermont Department of Health

Program Successes

Successful Programs exhibit the following key points:

1. When adequately funded, comprehensive state tobacco prevention programs can quickly and substantially reduce tobacco use.

2. State tobacco control programs must be insulated against the inevitable attempts by the tobacco industry to reduce program funding and otherwise interfere with the programs' successful operation.

3. Programs must be sustained over time both to protect initial tobacco use reductions and to achieve further cuts in smoking rates.

California

In 1988, California voters approved Proposition 99 which increased the state tax on cigarettes by 25 cents per pack. With 20 percent of the tax from the initiative (over $100 million per year) earmarked for health education against tobacco use, the California Tobacco Control Program was launched in the spring of 1990.

Despite increased levels of tobacco marketing and promotion, a major cigarette price cut in 1993, tobacco industry interference with the program, and periodic cuts in program funding, the effort has substantially reduced tobacco use.

California estimates that there have been over 10,800 fewer premature births with medical complications as the result of its program.

• Since the passage of Proposition 99, cigarette consumption in California has declined by 38 percent, twice as much as the decline of only 16 percent in the rest of the country.

• Since the passage of Proposition 99, adult smoking in California has declined at twice the rate it declined in the previous decade. From 1988 to 1996, adult smoking in California decreased from 26.7 percent to 18.1 percent.

• Even after the tobacco industry was successful in dramatically reducing the funding for tobacco control in California, cigarette consumption declined more in California than in the rest of the country.

• Since 1992, smoking among 10th graders in California has remained relatively constant at 18 to 19 percent while increasing from 22 percent to 32 percent in the rest of the country.

• More than 1.3 million Californians have quit smoking because of the California Tobacco Program.

Massachusetts

In 1992, Massachusetts voters approved a referendum, known as Question 1, that increased the state cigarette tax by 25 cents per pack. Part of the new tax revenues were used to fund the Massachusetts Tobacco Control Program (MTCP), which began in 1993. Again, despite some reductions in funding encouraged by the tobacco industry, the program has achieved considerable success, as shown by an ongoing independent evaluation of the program.

• Cigarette consumption in Massachusetts has declined by 31 percent since 1992, compared to a decline of just 7 percent in the rest of the country (excluding California).

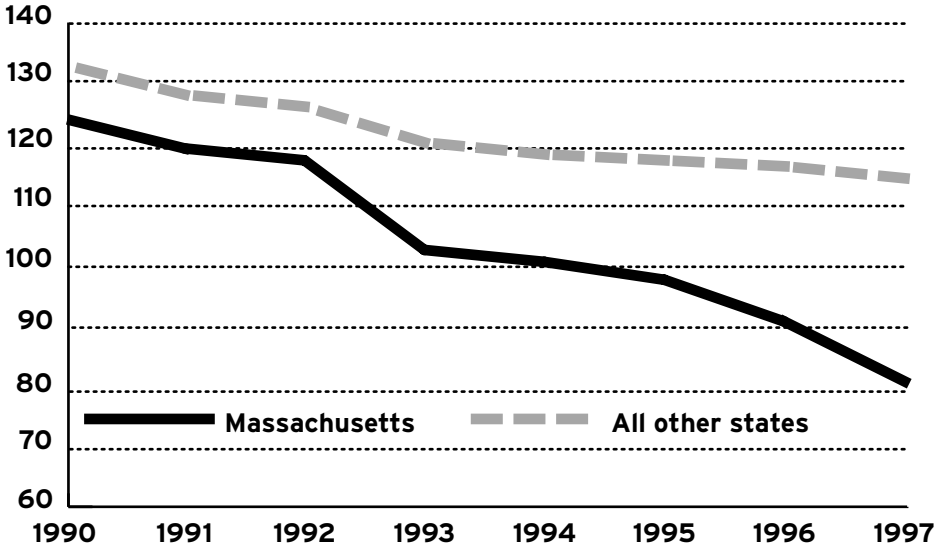
• Those who do smoke in Massachusetts are smoking less. While 26 percent of smokers in 1993 were "heavy smokers," (more than a pack a day) only 16 percent smoked at this level in 1996-97.

• Between 1993 and 1996, smoking among 8th graders in Massachusetts decreased slightly, while it increased dramatically throughout the rest of the country. Among 10th and 12th graders, smoking rates increased less in Massachusetts than in the rest of the country.

• The proportion of tobacco retailers in Massachusetts making illegal sales to youth in compliance checks has fallen from 48 percent to only 8 percent.

Packs of Cigarettes: Annual Purchases Per Adult

Source: Massachusetts Tobacco Control Program



*Note: 1997 estimate based on first 6 months

Massachusetts saves $3 in health care costs for every dollar spent. The State estimates that its programs have paid for themselves from the reduction in premature births and low birthweight babies.

Oregon

Oregon's voters increased cigarette excise taxes from $.38 to $.68 per pack in 1996, which supported a new comprehensive tobacco prevention and education program.

• Oregon became the fourth state to pass a citizen initiative to raise tobacco taxes and dedicate a portion of the revenue to tobacco prevention and education programs. Other states that have passed similar initiatives are California (1988), Massachusetts (1992), and Arizona (1994).

• The state's program reduced cigarette consumption by 11.3 percent between 1996 and 1998, reversing a 2.2 percent rise in consumption from 1993 to 1996.

• Preliminary adult smoking prevalence data show a 6.4 percent decline from 1996 to 1998.

• Oregon's 15.8 percent increase in cigarette price alone was projected to result in only a 6.3 percent decrease in cigarette consumption. However, the reported 11.3 percent decline adds support to other analyses that have concluded that states have better results in reducing cigarette consumption when cigarette tax increases are coupled with comprehensive statewide tobacco prevention and education programs.

Florida

One of four states to settle with the tobacco industry prior to and separate from the fall 1998 multi-state settlement agreement, Florida launched a tobacco prevention pilot project in 1997. Tobacco companies made an initial payment of $893.5 million to Florida, and will make annual payments between $440 and $822.1 million. In 1997-98, $23.2 million was allocated for planning and initiating the project, and in 1998-99, $70 million was spent on full first-year implementation of the project.

The Florida Tobacco Pilot Program is distinctive in many ways. It is the first state program funded by a tobacco lawsuit settlement, the first to be designed specifically to combat and prevent youth tobacco use, and the first to be designed largely by its target audience, youth.

The Florida Department of Health Office of Tobacco Control created the initial framework for the program based largely on existing literature and input from the Centers for Disease Control and Prevention. This framework was refined in March 1998 by students at a Teen Summit.

The results of the pilot project were reported in March 1999.

• Settlement funds enabled the state to develop over 400 trainers to implement curriculum, which reached over 940,000 students in 1998.

• Early results indicate that more than 90 percent of teens are aware of the campaign.

• From April to September 1998, the proportion of teens who "strongly agree" that smoking has nothing to do whether a person is cool increased from 48 percent to 59 percent.

• After one year of full implementation, tobacco use among middle school students dropped by 19 percent (3.5 percentage points) and tobacco use by high school students dropped by eight percent (2.2 percentage points). At this stage of the pilot project, the governor and legislature must now decide funding levels each year to continue the program.

Mississippi and Minnesota

Mississippi and Minnesota are two recent programs, not yet ready for full evaluation. Programs in both states will be administered by an independent board. In Mississippi the court ordered the establishment of an independent board to administer the settlement funds. *(See page 30 for details.)* ■

Sources: National Campaign for Tobacco-Free Kids and National Association of Attorneys General

Section 3: The Task Force Plan

Last spring, the Vermont House of Representatives in preliminary discussions recommended that the state devote the entire annual tobacco settlement to tobacco control and other related health promotion programs. The Governor and the Legislature then appointed the Tobacco Task Force to develop a comprehensive tobacco prevention, control, and cessation plan.

Task force members strongly believe, from what they heard at the public forums and from the testimony of experts, that spending the bulk of the settlement payments on comprehensive statewide tobacco prevention and cessation programs is the right course.

The Task Force believes that the settlement payments give the state an historic opportunity to improve the health of all Vermonters. Comprehensive, well-funded, sustained programs can substantially reduce smoking and other tobacco use and save thousands of Vermont lives and millions of taxpayer dollars, research shows.

National studies in the early 1990s estimated that each pack of cigarettes sold will eventually cost society about $2 in medical care costs.

Research shows that money invested in prevention programs, pays for itself many times over in reducing future medical and indirect economic costs.

Money invested in cessation programs provides more immediate health and economic benefits: smokers who quit have better health in the short- and long-term, reducing health care costs. Cessation programs are also a necessary complement to prevention programs. As the numbers of smokers decline, the social acceptability of smoking also declines. A comprehensive program would dramatically improve public health, and do more to help Vermont and its citizens than any other use of settlement funds.

The following sections explain why the Task Force believes so strongly in investing the tobacco settlement in tobacco and health-related programs:

• Guiding principles: program development;

• Why Vermont should use its settlement on cessation and prevention programs;

• The cost of a comprehensive program and suggests some Vermont program initiatives;

• Options, such as the creation of endowments, trusts, or foundations, that will protect states from the uncertainty of future tobacco company payments;

• Guiding principles in administration of the tobacco settlement money.

The final section summarizes the Task Force's recommendations to fund equally three tobacco and health-related programs and to create an independent administrative board.

Guiding Principles: Program Development

• **Programs must be comprehensive.** Stopgap or partial measures will meet with only partial success. While research shows that a number of measures can reduce tobacco use, these elements work most effectively when they are combined in complementary fashion.

• **Programs must be well funded.** Unless properly financed, tobacco prevention will have little effect against the marketing efforts of the tobacco industry, over $5 billion each year nationally and an estimated $11-million plus in Vermont.

• **Programs must be sustained over a long period of time.** While short-term attitudinal changes can occur relatively early, it will take years to achieve the significant behavioral and cultural changes necessary to reduce tobacco use substantially and maintain low levels.

If tobacco control programs are not sustained over many years, the chances for success will be diminished, and any early gains may be lost in subsequent years. The early investment must be protected by sustaining the effort over time.

• **Programs must operate free and clear of political and tobacco industry influence.** History warns us that the tobacco industry will employ a variety of tactics to divert money from tobacco prevention and to interfere with any tobacco prevention efforts. To avoid this tobacco industry sabotage, new tobacco prevention and cessation programs must be set up to be independent of these influences and insulated from them.

• **Programs must address high-risk and diverse populations.** The needs of special populations can and must be taken into account in designing and disseminating the various elements of the tobacco control program.

• **Programs must be effective.** Only programs that have been proven effective and are rigorously monitored and evaluated should be funded.

Since 1991, the number of kids under 18 who smoke has increased by more than 30 percent.

Why Vermont Should Use Settlement Funds for Prevention and Cessation Programs

Tobacco payments to Vermont are meant to compensate the state for past tobacco-related harms and related costs. Accordingly, the payments should be used to reduce the damage future tobacco use will cause Vermont. That means using settlement funds to sharply curtail smoking and other tobacco use, especially among youth and to help support smokers who want to quit.

Public Supports Prevention Programs for Youth

In a 1998 pre-election poll of about 600 likely Vermont voters, 91 percent said that about half or more of any settlement funds should be spent to reduce smoking among kids.

Similarly, in a recent nationwide poll, 84 percent of respondents favored spending the money their state receives to reduce tobacco use among kids, including more than two-thirds (69 percent) who "strongly favor" spending the money for this purpose.

The Smoking Problem Is Big And Getting Worse

About 25 percent of adult men and 21 percent of adult women currently smoke in Vermont, along with 36 percent of all high school students. Adult smoking has generally been declining in recent years. But the number of kids who are smoking, largely because of increased tobacco company advertising and promotions, has been increasing steadily throughout the 1990s and has only recently declined slightly.

Since 1991, the number of kids under 18 who smoke has increased by more than 30 percent. In Vermont, more than 2,000 kids under 18 become new daily smokers each year.

Comprehensive Tobacco Prevention Programs Work

Vermont has had programs, but the state has never had the resources for a comprehensive statewide program. California and Massachusetts have already initiated tobacco control campaigns that are reducing their overall smoking levels at a faster rate than elsewhere in the country.

While youth smoking rates were rising steadily nationwide, California and Massachusetts use rates either went down or increased much more slowly—despite significant reductions to their tobacco control efforts and in spite of aggressive tobacco industry efforts to dampen the impact of the state programs.

New Tobacco Prevention Spending Will Save Lives

Tobacco use is responsible for more deaths than alcohol, auto accidents, AIDS, suicides, murders, and illegal drugs combined. Each year, nearly 1,000 people die from smoking-related causes in Vermont. Countless others suffer from tobacco-related disease and distress, including many of those exposed to secondhand smoke. If current smoking trends are not reversed, roughly 12,000 of today's Vermont children will eventually die from smoking-related causes.

Spending on Prevention Will Save Vermont Money

Public and private direct expenditures in Vermont to treat health problems caused by smoking now exceed $200 million annually, with the state government paying about $30 million every year in cigarette-related Medicaid expenditures. Vermont and its citizens annually pay millions more for health care relating to smokeless tobacco use, cigar, and pipe smoking. Exposure to secondhand smoke adds even more to the health costs from tobacco use.

Beyond direct health expenditures, there are tobacco-related labor costs and lost productivity; damage and loss from cigarette-related fires; and tobacco-related maintenance and cleaning expenses. Aggressive statewide tobacco prevention initiatives would reduce these tobacco-related costs and save Vermont, its businesses, and its citizens millions of dollars every year.

Nickel And Diming The Problem Won't Work

Significantly reducing tobacco use in Vermont requires substantial investment in a sustained and comprehensive multi-year tobacco prevention strategy. Anything less will not effectively counter the addictive power of nicotine or the tobacco companies' advertising and marketing expenditures (more than $13 million per year in Vermont).

National prevention efforts show that the best way to reduce tobacco use, other than by raising prices, is to employ a wide range of proven effective measures. These measures include public education efforts, school and community-based programs to prevent tobacco use and to help people quit, increased enforcement of laws prohibiting the sale of tobacco products to youth, and the firm maintenance of smoke-free workplaces and public areas.

While any one of these tobacco control measures can reduce tobacco use by itself, they work much more powerfully and effectively when done together.

From 1996 to 1998, tobacco consumption in Oregon declined by 11.3 percent, with almost half the decline (5 percent) attributable to a comprehensive tobacco prevention program.

National Efforts Aren't Enough

Although the settlement contains some useful restrictions on tobacco marketing, they will not, by themselves, significantly hinder the tobacco industry's ability to market to kids. Similarly, the new national public education campaign financed by the multi-state settlement can significantly reduce tobacco use only if it is accompanied by strong state tobacco prevention and cessation efforts, including new state public education strategies.

Put simply, the tobacco settlement can dramatically cut tobacco use in Vermont only if the state uses these payments to finance new tobacco prevention and cessation initiatives.

Settlement Funding for Other Purposes

The U.S. Centers for Disease Control and Prevention estimate that adequately funding a comprehensive tobacco control effort in Vermont would cost $7.9 to $15.9 million per year. Vermont could create a strong new tobacco control program and still have roughly $10 million or more per year for other purposes.

Prevention Spending Will Not Waste Money.

Tobacco control efforts throughout the country have been carefully researched and evaluated. The Task Force proposal would only support tobacco prevention and cessation initiatives that have successful track records.

To further enhance cost effectiveness, the Task Force plan requires that all new tobacco control activities be carefully monitored and evaluated, both to avoid fraud and abuse and to improve program performance.

Sources: Vermont Department of Health; Coalition for a Tobacco-Free Vermont; and Centers for Disease Control and Prevention (CDC)

Funding a Comprehensive CDC Prevention and Cessation Program

Centers for Disease Control and Prevention recommendations rely on "best practices" determined by the analysis of comprehensive state tobacco control programs.

Using these evaluations, the CDC has developed program recommendations and high and low cost estimates for these programs. Funding will vary depending on state characteristics, such as demographic factors, tobacco use prevalence, and other factors.

The CDC estimates that a comprehensive tobacco control program in Vermont would cost from $7.9 million to $15.9 million per year. The Task Force recommends using one-third of the annual tobacco settlement.

Using one-third of the settlement, Vermont would be funding programs at the lower end of the CDC's recommendations and still have money left for other health-related programs.

The Vermont Department of Health, along with other state agencies such as the Department of Education and Department of Liquor, and non-profit organizations such as the Coalition for a Tobacco Free Vermont and the local chapters of the heart, lung, and cancer associations, have developed and cooperated on a number of the following suggested initiatives.

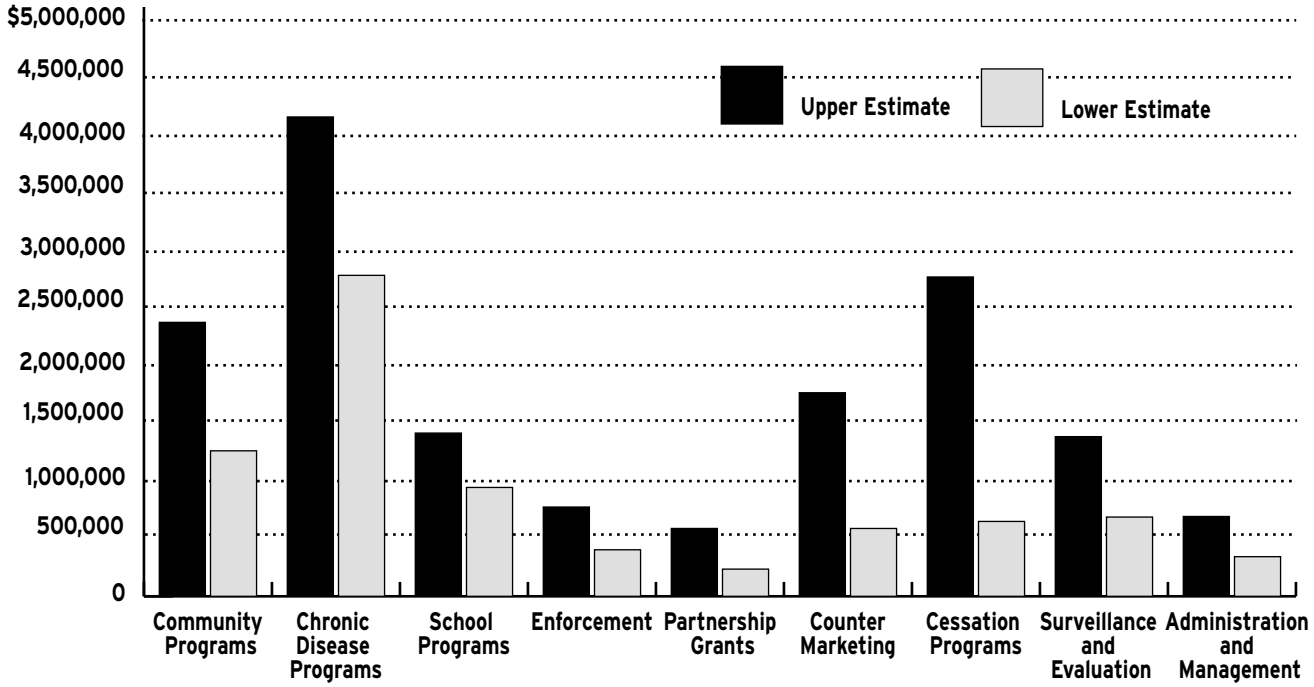
The Department of Health, with federal and non-profit organization funding, has established community grant programs, has worked with the Coalition on counter-marketing campaigns, has supported training programs for teachers, and has coordinated a peer telephone support cessation program for pregnant women.

The Department also coordinates a biannual behavioral risk survey that monitors youth tobacco, drug, and alcohol use.

All these programs provide a foundation for the much more comprehensive programs to be supported by the settlement.

CDC Estimates of a Comprehensive Tobacco Program in Vermont

Source: Centers for Disease Control and Prevention



Components of a Comprehensive Program

1. Community Programs to Reduce Tobacco Use

Vermont Upper Estimate $2,378,000
Lower Estimate $1,263,000

Local community programs cover a wide range of prevention activities including engaging youth in developing and implementing tobacco control interventions; developing partnerships with local organizations; conducting educational programs for young people, parents, enforcement officials, community and business leaders, health care providers, school personnel, and others; and promoting governmental and voluntary policies to promote clean indoor air, restrict access to tobacco products, provide coverage for treatment, and achieve other policy changes.

Possible Vermont Initiatives

• Increase the capacity of local communities and schools in Vermont by strengthening the tobacco control infrastructure in the state and by providing a shared vision for all tobacco control advocates.

• Establish a grant program that will allow local health departments and community agencies to obtain funding for staff and resources to implement programs and support local partnership initiatives.

• Work with dental societies and other related organizations to provide free oral screening to children and adults who do not have access to dental care. These screenings should be provided in areas where smokeless tobacco is used and where there is a high incidence of oral cancer.

• Provide additional resources to coordinate compliance checks of tobacco sales to minors over and above those required by the FDA and Synar Amendment.

• Develop a training program to educate retailers and their employees on the importance of prohibiting the sales of tobacco products to minors. Education of the laws coupled with compliance checks will help reduce illegal sales to youth.

• Expand training of law enforcement officials involved in underage alcohol enforcement to include tobacco. Many retailers perceive the sale of alcohol to underage youth seriously because there is active enforcement of the law and because there are penalties for being caught. An active enforcement program, coupled with retailer education, will lead to reduced tobacco sales to minors.

• Provide training and technical assistance through the Vermont Medical Society, Vermont State Nurses Association or other health groups to educate and assist health professionals on strategies to facilitate smoking cessation among high-risk patients.

2. Programs to Reduce the Burden of Tobacco-Related Diseases

Upper Estimate $4,161,000
Lower Estimate $2,786,000

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

Possible Vermont Initiatives

• Cardiovascular disease prevention and rehabilitation programs

• Asthma prevention and education programs for adults and youth

• Oral health programs

• Maintenance of a comprehensive state cancer registry

"Prevention, prevention, prevention, prevention. Close your eyes and think of your children being asked/pressured to try (smoking), because 'everyone is doing it.'"

– Participant at Burlington Public Forum

3. School Programs

Upper Estimate $1,417,000
Lower Estimate $944,500

School program activities include implementing CDC's Guidelines for School Health Programs to Prevent Tobacco Use and Addiction, which call for tobacco-free policies, evidence-based curricula, teacher training, parental involvement, and cessation services; implementing evidence-based curricula identified through CDC's Research to Classroom Project; and linking school-based efforts with local community coalitions and statewide media and educational campaigns.

4. Enforcement

Upper Estimate $775,000
Lower Estimate $404,000

Enforcement deters violators and sends a message to the public that community leaders believe that these policies are important. Two areas that require active enforcement are restrictions on minors' access to tobacco and restrictions on smoking in public places.

California and Massachusetts have addressed enforcement issues as part of community program grants. Florida has taken a more centralized approach by using State Alcoholic Beverage Control Officers to conduct compliance checks with locally recruited youth in all regions of the state.

5. Partnership Grants

Upper Estimate $589,000
Lower Estimate $236,000

Statewide projects can increase the capacity of local programs by providing technical assistance in evaluating programs, promoting media advocacy, implementing smokefree policies, and reducing minors' access to tobacco. Supporting organizations that have statewide access to racial, ethnic, and diverse communities can help eliminate the disparities in tobacco use among a state's various population groups.

Statewide and regional grants to organizations representing cities, business and professional groups, law enforcement, and youth groups inform their membership about tobacco control issues and encourage their participation in local efforts.

Possible Vermont Partnerships

• Work with the professional health care organizations, such as the Vermont Medical Society the Vermont Dental Association and the Association for Hospitals & Health to set standards of care and training in tobacco prevention and cessation.

• Sponsor information-sharing meetings through UVM, American Lung Association, and American Cancer Society.

• Set up quit smoking hotlines for all communities.

• Set up working group to assist communities in helping difficult-to-reach youth. Most prevention and cessation programs for adolescents have taken place in schools. There are young people, however, who may not attend traditional schools, but who are at high risk for tobacco use.

These young people may be housed in youth detention facilities, group homes for troubled youth or may be part of a Job Corp program. Partnering with the agencies and organizations that run these programs has the potential of assisting a very vulnerable population.

For those who are no longer in high school, partnering with the states' colleges, universities and technical schools would increase the likelihood that this age group would be reached with stop smoking and cessation messages.

• Work to educate businesses about smoking restriction laws. Organizations can provide leadership as well by working with business to promote smoke-free workplaces and requesting cessation services on site as well as health care coverage for cessation services outside of the workplace.

• Partner with law enforcement agencies to promote and enforce Vermont's current tobacco control laws. In addition, funding could be provided for involvement of local police agencies in compliance checks. Enforcement has been found to be a key to reducing youth access to tobacco products.

6. Counter-Marketing

Upper Estimate $1,767,000
Lower Estimate $589,000

Counter-marketing attempts to rebut pro-tobacco messages and to increase pro-health attitudes throughout a state, region, or local community. Counter-marketing can include paid television, radio, billboard, and print counter-advertising at the state and local level; media advocacy and public relations activities, such as press releases, local events, and health promotion activities; and efforts to reduce or replace tobacco industry sponsorship and promotions.

Counter-marketing activities can promote smoking cessation and decrease the likelihood of initiation. They also can have a powerful influence on public support for tobacco control interventions and set a supportive climate for school and community efforts.

Counter-marketing campaigns are a primary activity in all states with comprehensive tobacco control programs. With funding levels ranging from less than $1.00 per capita up to almost $3.00 per capita, the campaigns in California, Massachusetts, Arizona, and Florida have been trendsetters in content and production quality.

Possible Counter-Marketing Initiatives in Vermont

The public health community will never be able to match tobacco industry spending dollar for dollar, but with appropriate resources, the state can counter tobacco marketing. In addition there are many opportunities to leverage advertising dollars for free public service space or time for non-profit ventures.

One goal of a statewide counter-marketing program would be to change the misperception, especially among the group most at-risk for starting a tobacco habit — children and teenagers ages 11 to 15 — that smoking is the norm, not the exception.

• Base counter-marketing strategies on market research and data already available from other parts of the country. Youth should be involved in the creative process.

• Work with movie theater chains to show anti-tobacco advertisements prior to movies and to feature anti-tobacco posters/signage in the lobby areas.

• Contract with a webmaster to develop an interactive web site that will appeal to youth. Also, make concerted efforts to link with sites adolescents and teens frequent.

• Partner with major convenience store chains and grocery stores to develop and use anti-tobacco point-of-purchase materials and other store signage in place of the tobacco counter mats and displays provided by the tobacco industry.

7. Cessation Programs

Upper Estimate $1,772,000
Lower Estimate $650,000

Strategies to help people quit smoking can yield significant health and economic benefits. Effective cessation strategies include brief advice by medical providers, counseling, and pharmacotherapy. In addition, system changes (e.g., tobacco-use screening systems, clinician training, and insurance coverage for proven treatments) are critical to the success of cessation interventions.

State action should include establishing population-based treatment programs such as telephone cessation helplines; covering treatment of tobacco use under both public and private insurance; and eliminating cost barriers to treatment for underserved populations, particularly the uninsured.

Possible Cessation Activities in Vermont

• Set up a toll-free counseling telephone help line and website.

• Provide financial support for medication and counseling.

• Partner with professional associations to train citizens to facilitate cessation programs.

• Train counselors at each mental health/drug abuse facility to give smoking cessation counseling.

• Educate people who work with teens such as teachers, coaches, school nurses, and church youth group leaders about youth tobacco cessation programs.

"Smoking cessation and treatment should be available to every smoker in Vermont regardless of ability to pay.

– Participant at Rutland Forum

• Create ads urging adults to stop.

• Set up helpline of experts in cessation for counselors and other health professionals to call for consultations.

• Set up referral centers where doctors and others can send patients with severe addiction problems.

• Set up regional clinics that offer weekly evening office hours.

• Fund and establish work-site cessation programs to assist employees who wish to give up smoking.

• Fund behavior research into the most effective ways to reach tobacco users with cessation messages and targeted programs.

8. Surveillance and Evaluation

Upper Estimate $1,386,000
Lower Estimate $688,000

A surveillance and evaluation system monitors programs for state policymakers and others responsible for fiscal oversight. Surveillance monitors tobacco-related behaviors, attitudes, and health outcomes at regular intervals of time. Evaluation builds upon surveillance systems and examines whether statewide and local programs are meeting their objectives.

Experience in California, Massachusetts, and other states has demonstrated that the standard public health practice guideline of devoting 10 percent of program resources to surveillance and evaluation is a sound recommendation.

Possible Vermont Initiatives

• Evaluate any non-science based programs that communities try.

• Calculate cost per prevented smoker and cost per quitter for programs.

• Collate evidence from multiple sources: tax revenues, per capita consumption, surveys, and sting results into an annual report.

9. Administration and Management

Upper Estimate $693,000
Lower Estimate $344,000

An effective tobacco control program requires a strong management structure to facilitate coordination of program components, involvement of multiple state agencies (e.g., health, education, and law enforcement) and levels of local government, and partnership with statewide voluntary health organizations and community groups. In addition, administration and management systems are required to prepare and implement contracts and provide fiscal and program monitoring.

Experience in California and Massachusetts has demonstrated that at least 5 percent of program resources is needed for adequate staffing and management structures.

Trust Funds, Endowments, and Foundations: A National Perspective

Many governors (and state policymakers) are considering the establishment of trust funds, endowments, and foundations to manage and administer tobacco settlement payments. Trust funds, endowments, and foundations are usually established to segregate funds in a budget, codify policy and intentions for spending the funds, or to preserve funds for future use.

All are instruments by which funds or assets may be reserved for specific purposes, and there are guiding principles that dictate their management. The governing instrument is the critical component of successful fund administration.

Governmental trust funds are usually created to reserve revenue for specific purposes. They have varying degrees of oversight and management.

Endowments are commonly used when parties wish to preserve a base amount of funds in perpetuity or for some long period of time. The funds are usually kept apart from other assets. Only the interest income, or a portion of the income, is used to support specific objectives outlined in a charter or governing instrument.

Foundations are nonprofit, philanthropic entities established to aid and maintain charitable activities. They are often in the form of a trust fund, although some foundations have endowments.

Planning and establishing concise goals and accountability measures are critical to successful fund management, regardless of how a state receives and manages tobacco settlement funds. Key questions are:

- What are the state's legal and constitutional constraints associated with the various options?
- Is the state planning to spend principal, interest, or both?
- What is the best structure to administer the funds?

Source: National Governors Association

Administration of Settlement Funds

Governing instruments. Overly strict wording in guiding principles, trust instruments, and charters may hamper a state's' ability to meet legitimate, unforeseen needs in the future. Alternatively, a loosely worded governing instrument may allow for spending on activities inconsistent with the fund's purposes. Clearly stated goals and purposes will allow states to set priorities and manage them effectively.

Fund management mechanisms. In addition to foundations, some states are establishing governing boards or commissions to guide spending and initiative development. These management tools are often separate from government and are solely dedicated to advancing a fund's purpose and mission. Explicit board requirements and gubernatorial input on these appointments will ensure accountability and proper fund management.

For example, Governor Gilmore will appoint the majority of Virginia's commission and foundation members, and the enabling legislation specifically outlines their responsibilities.

Evaluation tools. Measuring the benefits of fund use will challenge states. Many constituencies will want to see where tobacco monies have positively affected problem areas and communities. Smoking prevention and cessation programs will obviously warrant performance measures, but so will programs that provide health insurance to children, assist farmers, and provide educational opportunities to youth.

With the flexible characteristics of trust funds, endowments, and foundations, governors (and legislatures) have broad latitude to design and name fund management entities. They can design entities according to their states' short- and long-term needs and priorities through the governing instruments.

Several external variables could affect state payment amounts and expenditure plans. The tobacco industry is in perpetual litigation, and state legislatures continue to pass additional tobacco taxes. The master settlement agreement also will affect the tobacco-use landscape with its restrictions on marketing and lobbying. It has already increased the price of cigarettes and other tobacco-related products. Experts have not yet determined the impact of these lawsuits, the additional taxes, or the settlement components on the long-term viability of the industry.

Given the uncertainty of the settlement payments to states, governors (and legislatures) should consider protecting some of the funds for the future or at least postponing payment expenditures until they are in state possession.

Source: National Governors' Association

There is no silver bullet to solve the problem of tobacco use. Tobacco prevention requires strategic planning and coordination of research, policy, and programs for maximum effectiveness.

Principles of Administration

Another perspective on the development of a structure to administer tobacco funds comes from the Health Sciences Analysis Project.

1. Ensure adequate funding

Funding should be sufficient to provide the full range of services, programs, and policies that comprise a comprehensive tobacco prevention strategy.

2. Provide secure, long-term support

A steady stream of funding is necessary to keep policy implementation consistent and effective. Funding from sources developed for tobacco prevention should be directed to those efforts, and should not be diverted to other causes, however worthy, if the diversions undermine the public education and health promotion goals of the original initiative, law, or settlement agreement.

Since all legislatures face pressures to shift available funding to competing priorities, it is important to make specific provisions to protect tobacco control funds for their intended purpose.

3. Implement and coordinate multiple strategies, at national, state and community levels

There is no silver bullet to solve the problem of tobacco use. Tobacco prevention requires strategic planning and coordination of research, policy, and programs for maximum effectiveness. Strategies at the local, state and national levels should be pursued, and should be designed to work together and avoid redundancy to the maximum extent possible.

State-level organizations with the authority to set funding priorities, working with national policymakers, other state health authorities, and local stakeholders, can provide this kind of coordination and leadership.

4. Ensure independence from direct and indirect tobacco industry influence

Tobacco industry representatives should be prohibited from program participation, administration, and oversight. In addition to the obvious conflict of interest between the tobacco industry and efforts to reduce tobacco use, the industry has a history of interfering in tobacco control efforts in ways that waste taxpayer dollars, and are detrimental to public health goals.

5. Involve a wide range of public health stakeholders

It is critical to ensure that diverse voices and views are heard in implementing tobacco control policy. But those involved in such decisionmaking must share a commitment to implementing a strong, aggressive tobacco control program; and to succeed in fulfilling this commitment, they must bring to the process all available expertise and real-life experience in building effective programs and policies.

For these reasons, the fullest possible range of public health experts should be involved in directing tobacco control programs, including those with strong scientific credentials, public policy expertise, and experience in pro-health community activities. Those with interests inconsistent with effective tobacco control — especially those with an interest in undermining the program — should not be involved.

6. Base programs and policies on proven public health strategies

Just as experts reflecting the full range of public health skill and experience should be involved in implementing a tobacco control strategy, those experts should be permitted to use all effective public health measures and methods in designing that strategy. The fundamental criterion for judging an approach should be: Is it effective?

No artificial conditions or requirements should be placed on strategies permitted for use by the tobacco prevention program. All strategies should be based on sound science and proven policy experience. In particular, no age targets, prohibitions on industry "attacks," or other limits should be imposed.

Further, a comprehensive strategy must include a significant evaluation component, and implementers should be permitted to discard ineffective strategies, focus resources on those found particularly useful, and to experiment with new and improved approaches.

7. Support advocacy

Comprehensive programs and policies must be advanced and supported by a vigorous tobacco control movement, including policy advocacy, in states and localities nationwide. But tobacco policy advocates, characterized as "special interest lobbyists," have been confronted with burdensome information requests and dilatory legal challenges by industry-affiliated law firms.

A comprehensive program should recognize and support policy advocacy with resources and with safeguards from intimidation by the tobacco industry and its surrogates.

8. Prevent preemption

Development of a comprehensive tobacco control program should be not used as an excuse to stop further state and local efforts. Any agreement or legislation codifying a tobacco prevention program should include an explicit acknowledgment that it is not intended to preempt additional activities.

Source: Health Science Analysis Project

Administrative Structure: New Thinking Is Required

While the principles described above reflect years of tobacco control experience, developing an administrative and policymaking structure in the wake of the Master Settlement Agreement and state suits requires new thinking.

One clear option for states is to make the program part of a state's health department; many states now administer tobacco control programs this way, and there are some advantages to this approach. However, there are also important caveats that should be addressed in assigning this new responsibility to state health departments:

• State departments are diverse in mission and in scope of responsibilities — and properly so. But the uniquely devastating impact of tobacco on health requires a special administrative focus.

• The tobacco industry has already shown a willingness and ability to undermine the tobacco control efforts of state health departments. Policymakers must protect the administrative structure of tobacco control programs to prevent the industry from sabotaging them.

• Because tobacco control funding comes, either directly or indirectly, from smokers' suffering, settlement funds should be dedicated to eradicating tobacco's impact, rather than dispersing it among other public priorities, however worthy.

• The administrative structure of the program must be made flexible enough to permit partnerships with a diverse range of public and private interests.

For these reasons, the Task Force and health authorities, such as the Koop-Kessler Advisory Committee, have recommended establishment of independent, non-profit entities to implement tobacco control policy.

The Task Force Plan

Vermont has been a national leader in anti-tobacco and clean air legislation. The Task Force's recommendation to devote all the settlement to tobacco prevention, control, and cessation programs and for tobacco-related health expenses would continue Vermont's leadership role and create one of the most aggressive anti-tobacco efforts in the country.

Our program would split the settlement among three mutually supportive components:

• A Statewide Comprehensive Tobacco Program: 1/3, approximately $8 to $10 million.

The Centers for Disease Control and Prevention— the country's leading authority on reducing tobacco death and disease — has recommended spending from $7.9 million to $15.9 million annually in Vermont. The Task Force's plan to spend about $10 million per year on a comprehensive prevention and cessation program is at the lower end of the CDC's recommendations.

The CDC's recommendation is designed specifically for Vermont. Massachusetts, considered to be one of the most successful states in reducing adult and youth consumption, is about to increase its total investment in its tobacco prevention program to $14.30 per capita. Because Vermont is such a small rural state and cannot benefit from the economies of scale enjoyed by Massachusetts and other larger states, the CDC recommends a higher level of per capita investment for Vermont.

Comprehensive smoking programs are expensive, but they save money and lives in the long run. The average smoker spends $20 a week, the Task Force proposes spending less than that over a year per capita to prevent and curb smoking and to create a healthier Vermont.

• A Permanent Tobacco Control Trust Fund: 1/3, approximately $8 to $10 million.

The Task Force believes the state cannot and should not rely on tobacco industry money over the long-term to support essential health care and anti-tobacco programs. Like task forces in many other states, we are recommending the creation of a special trust fund to support future anti-smoking and health programs. By placing $10 million each year from the tobacco settlement into a fund, the state can build an endowment of at least $150 million, which could then fund the program regardless of industry payments.

• Support of Other Health Programs: 1/3, approximately $8 to $10 million.

The state spends an estimated $30 million a year to support smoking-related health care benefits for low-income Vermonters. The Task Force recommends spending $10 million a year to help the state pay for these benefits.

Public forum attendees told the Task Force that they didn't want the annual settlement money to be "raided" for tax cuts or for other non-tobacco-related programs, however worthwhile.

An Independent Board

The Task Force supports the creation of an independent board, patterned after the independent board of the Vermont Housing and Conservation Trust Fund, to administer the state's tobacco program. This board would include a cross-section of Vermonters concerned about tobacco use in Vermont. The Task Force strongly believes that an independent board, consisting of members of the public and private sectors, is the most effective way to ensure:

• Program investments are appropriately monitored and evaluated.

• Investment decisions are quickly modified or altered in the event that grants are not producing appropriate results within reasonable time frames.

• Creative partnerships with other states, federal government and the business community are maximized.

• State expenditures are leveraged to the greatest extent possible through grant monies from federal and private sources.

• All critical sectors of Vermont have a voice in the development of the tobacco prevention program.

Again and again at the forums, Task Force members heard Vermonters say that they didn't want all the program decisions to come from the legislature or from a state agency.

And they told the Task Force that they didn't want the annual settlement money to be "raided" for tax cuts or for other non-tobacco-related programs, however worthwhile. Settlement money should be kept separate, they said, and be used to address the state's number one preventable health problem, tobacco use.

An independent board that reports annually to the legislature and governor is the most effective way to utilize all Vermont's resources, the Task Force believes.

The proposed 13-member board, to be appointed by the Governor, would include the following: the Commissioner of Health, the Commissioner of Education, the Attorney General, two youth under age 18, a health care provider, a tobacco prevention expert, a smoking cessation expert, an addiction scientist, an advocate for the low-income community, a representative from the non-profit advocacy community, and a member from the House and Senate.

The board would be subject to customary legislative oversight and would submit an annual report to the Legislature and Governor by January 15. The board could approve programs funded by the one-third of the settlement devoted to prevention and cessation programs but would need the legislature's approval to draw from the principal of the trust fund.

The board would be supported by five advisory panels:

• Program Monitoring and Evaluation

• Prevention, with youth forming the majority of the panel

• Cessation

• Grant Review

• Enforcement.

The independent board would oversee the recruitment of a small administrative staff. This staff would work closely with experts throughout state agencies and the private sector.

Based on CDC recommendations, the Task Force would cap the costs of an independent board and administrative staff, at a figure not to exceed five percent of the annual settlement payment.

Minority Viewpoint

Two of the 11 members of the Task Force opposed some parts and supported other parts of the proposed plan.

One Task Force member, the Commissioner of Health, opposed the creation of an independent board, supporting instead the Department of Health's administration of the tobacco prevention and control program and associated funding. The Commissioner believes the Department has the expertise to manage the tobacco program and can more efficiently and effectively expand programs and get results.

Sen. Elizabeth Ready dissented on the level of spending and how the money may be spent. ■

Section 4: Task Force Meetings and Public Forums

The Tobacco Control Task Force, appointed by the Governor and Legislature last spring, was charged with developing long- and short-term plans to spend and/or invest the state's annual payment from the Master Settlement Agreement with the major tobacco companies. The report was to be completed no later than November 15 and presented to the Governor and Legislature.

Toward that end, the 11-member task force formally met 14 times over the summer and early fall. The task force's deliberations began with an organizational meeting on June 30 and concluded with a meeting on November 15.

During these meetings, the Task Force heard presentations from and questioned in-state and out-of-state experts on the establishment of tobacco prevention and cessation programs.

On July 6, the Task Force heard from two of its own members, John Hughes, M.D., a faculty member from the UVM College of Medicine and a nationally-known authority on cessation programs, and Brian Flynn, director of the Office of Health Promotion Research at UVM. In addition, the Task force heard from Richard Watts, chair of the Media Committee of the Coalition for a Tobacco Free Vermont. The Task Force selected the Watts Group in late August from a field of six applicants to publicize the task force's work, organize statewide forums, and write the task force's report to the Legislature and Governor.

On August 3, the Task Force heard a presentation, via speaker phone, from Charles Wolfe, founder and former director of the Florida's tobacco control program, and from Kitty Jerome, assistant director of Massachusetts' Tobacco Control Program.

In addition, Tom Pelham, commissioner of the Vermont Department of Finance and Management, appeared before the Task Force.

On August 9, 1999, the Task Force heard three more experts, via speaker phone: Richard Hurt from the Minnesota Tobacco Control Program; Nicole Boyd, from the Mississippi Tobacco Control Program; and John Lloyd, health promotion specialist in the California Tobacco Control Program.

On October 29, the task force heard from Matthew Paluszek, regional director of government affairs of the Philip Morris Company, Matthew Myers, executive vice president and general counsel of the Campaign for Tobacco-Free Kids, and Douglas Hoffman, a tobacco cessation program researcher.

Public Forums

In addition to these meetings and additional conference calls, the task force held six forums and one youth forum to listen to Vermonters' concerns and to solicit state residents' reactions to the task force's plan.

Approximately 300 people attended these interactive 90-minute-long forums in **Brattleboro, October 5; Rutland, October 6; St. Albans, October 7; Barre, October 12; St. Johnsbury, October 13;** and **Burlington, October 14.** At these forums, a task force member presented a quick overview of the task force plan before the participants split up into discussion groups of about 10 people with two facilitators.

In a series of brainstorming exercises, participants were first asked what their top priority would be if they could tell the governor how the state should use its tobacco settlement money. The small groups were then asked to suggest programs, ideas, and strategies, in such areas as prevention, cessation, and enforcement/control, to deal with tobacco and smoking in their communities.

Participants were also asked to evaluate the strengths and weaknesses of the task force's plan to split the tobacco settlement payment among three programs and to create an independent board to oversee the programs. At the end of the hour-long discussion, participants selected what they thought were the best ideas from the scores of suggestions. The forums concluded with a reporter from each group presenting a two-minute summary of the group's discussion to the entire body.

The youth forum at Windsor High School on October 15 was attended by over 200 students, grades 5 to 12, from surrounding schools and from as far away as Troy. The discussions were student led.

Forum Transcript. A transcript of forum comments and the Public Outreach Report are available from the Legislative Council's office.

In addition to the forums, the Task Force also received about 75 comments either individually or forwarded from the Legislative Council's office.

Public Outreach Report. This report details the efforts of the Task Force to stimulate a state-wide conversation on what to do with the tobacco funds, and invite new people, especially young people and other hard-to-reach groups, to participate in that discussion.

The report lists organizations invited to help publicize the forums, includes documents presented at the forums, and contains media coverage of the forums.

Testimony from Vermont and National Experts

The Task Force spoke with about a dozen experts from Vermont and from states with some of the most advanced and successful tobacco prevention and control programs. Members sought advice on a wide range of issues:

- Funding of a comprehensive tobacco program
- Desirability and role of a trust fund
- Administration of a tobacco control program
- Desirability of an independent board
- Oversight role of legislative bodies.

The Task Force solicited advice from experts in Massachusetts and California — both have comprehensive and successful tobacco programs that preceded the settlement with the tobacco industry. Task force members also spoke with representatives from Minnesota and Mississippi about how those states have been developing plans for their tobacco settlements. Both states settled individually with the tobacco industry, about a year before the national settlement, and are further along in their planning than most states. Both states have established independent administrative boards.

Finally, members spoke with a representative from Florida's plan. Florida has developed the most comprehensive youth-oriented prevention plan in the country.

Consultants were supportive of the Task Force's proposal to split the settlement into three programs and to oversee the program with an independent board. Consultants also warned of temptations and pressures to use settlement money for a variety of "sound good" and "nice to have" programs that would not reduce tobacco use.

State Plans

Florida

Youth leadership is a cornerstone of the program, with students leading SWAT, (Students Working Against Tobacco). Charles Wolfe, founder and former director the Florida Office of Tobacco Control, described Florida's youth-oriented counter-marketing "Truth" campaign and its education, training, and community partnership programs. *(See page 15 for details.)*

Massachusetts

Kitty Jerome, assistant director of Massachusetts' Tobacco Control Program, described the state's successful efforts over the past half dozen years to reduce tobacco use. *(See page 14 for details.)* The Massachusetts program is administered through the regional health departments, while the Florida's high-profile program is run out of the Governor's office

Minnesota

Under the agreement, Minnesota will receive an initial $1.2 billion over the next five years. Each year thereafter Minnesota will receive on average $210 million.

The Minnesota settlement also established a foundation, Minnesota Partnership for Action Against Tobacco (MPAAT), which will receive $202 million over the next 10 years to fund tobacco addiction treatment efforts as well as research related to tobacco use.

While Governor Jesse Ventura's proposal for the tobacco settlement funds did not include any funding for tobacco prevention programs, his later support for the endowments — including money for tobacco prevention — during the final legislative negotiations proved critical.

Governor Ventura originally proposed allocating the settlement funds into four separate endowments, the Minnesota Families Foundation Endowment, the Health Professionals Education and Medical Research Endowment, the Medical Education and Research Costs Endowment, and the Local Public Health Endowment.

The Minnesota Legislature did pass legislation to place $492.5 million of the tobacco settlement into Endowment Funds for tobacco prevention programs. Interest from the endowments will be managed by the Department of Health and spent for advertising and other tobacco prevention efforts.

The bill also creates a Public Health Endowment, which allocates approximately $10 million annually — $5 million for youth anti-smoking efforts and $5 million for programs to fight other youth health risks. This, in addition to the money flowing to MPAAT, provides a total estimated

The Partnership for a Healthy Mississippi, a private-public partnership, includes over 60 statewide governmental and nongovernmental organizations and more than 600 local organizations

allocation for tobacco prevention and cessation programs in Minnesota of $35 million annually.

The legislature also allocated $305.5 million of the tobacco settlement to set up a medical education and research endowment. The legislature did not allocate the remaining monies from the initial $1.2 billion payments that will be received over the next five years.

Further, the legislature and governor have not considered any proposals related to spending the state's annual payments—separate from the $1.2 billion initial payments—which begin in 2001.

Minnesota's state legislature created an independent board to administer tobacco prevention and cessation programs and to conduct research.

Mississippi

The state settled with the tobacco industry for $4 billion, with annual payments of $136 to $256 million, prior to and separate from the 1998 multi-state settlement agreement. In October 1997, the chancellor overseeing the tobacco litigation approved an order placing $62 million in escrow for the development of a state program to reduce youth tobacco use. The Partnership for a Healthy Mississippi, a private-public partnership, is charged by the court with implementing a comprehensive program to promote healthy tobacco-free lifestyles for young people.

Partnership membership includes over 60 statewide governmental and nongovernmental organizations and more than 600 local organizations.

During 1998, much of the planning for this pilot project was done. In 1999 and 2000, Mississippi will spend up to $62 million for the initiation and implementation of a tobacco prevention program. The seven-member Board of Directors, elected by the Partnership, oversees the activities and programs of the organization.

The program will focus on four key areas:

1. Community outreach, education, and school-based programs.
2. Compliance and enforcement of youth access laws.
3. Public awareness and advocacy.
4. Tobacco prevention and cessation.

In 1999, Governor Kirk Fordice signed into law legislation directing all settlement payments—other than those set aside for the tobacco pilot project—to a health care trust fund with no specific allocation for tobacco prevention. The law allows the legislature to appropriate interest and some of the principal from the fund each year for a broad range of health care purposes.

Neither the Governor nor the Legislature introduced proposals for using Mississippi's settlement funds for tobacco prevention until the pilot project is complete, although it is possible such proposals could be introduced later.

California

California has one of the country's oldest and most comprehensive tobacco prevention and cessation programs. Despite increased levels of tobacco marketing and promotion, a major cigarette price cut in 1993, tobacco company interference with the program, and periodic cuts in the program's funding, the program has still successfully reduced tobacco use substantially. *(See page 13-14 for details.)*

Program Consultants

John Hughes, M.D., and **Brian Flynn,** tobacco cessation and prevention researchers

Dr. Hughes, a faculty member from the UVM College of Medicine and a nationally-known authority on cessation programs, and Flynn, director of the Office of Health Promotion Research at UVM, both task force members, discussed current thinking on cessation and prevention programs.

Prof. Flynn reviewed research from the past 30 years on what works in youth prevention programs. The Life Skills program, for example, is taught in grades 6-9 and has proven successful in tobacco prevention, anti-alcohol, and anti-drug efforts. But health education alone is not enough and any prevention program must also include media campaigns, community-based programs, and enforcement of tobacco sales laws, he said.

Cessation programs do work and do save money on health care expenses because smokers immediately benefit from stopping, Dr. Hughes stressed. With new medications and the use of support services, such as telephone Quit Lines, about half of smokers who try to quit eventually do stop. But quitting is difficult and smokers often try half a dozen times before they are successful. There is very little research on cessation programs for teenagers, Dr. Hughes said.

Richard Watts, *media and meeting consultant*

Watts, chair of the Media Committee of the Coalition for a Tobacco Free Vermont. Watts discussed a public meeting process on tobacco issues that would include small discussion groups and that would be more collaborative, informal, and interactive than the traditional public hearing.

Tom Pelham, *Commissioner of the Vermont Department of Finance and Management*

Pelham reported that national consumption of tobacco had declined and that Vermont's annual settlement could be reduced by several million dollars a year. Pelham said the Governor's proposed budget for fiscal year 2001 would not appropriate more than $17 million from settlement funds for non-tobacco programs.

Douglas Hoffman, *tobacco prevention and cessation researcher*

Hoffman stressed that the task force should support research-proven programs and carefully evaluate all programs. Hoffman also pointed out the danger of conflicts of interest among board members who might be involved in supporting programs that benefit their organization or themselves. The Task Force, aware of the potential for conflicts in a small state, has created five advisory boards to review programs and make recommendations to the board.

Matthew Paluszek, *regional governmental affairs director of the Philip Morris Management Corp*

Paluszek told the Task Force that Phillip Morris wanted to work with the states in combating teenage smoking and had established a $100-million national community projects and media campaign to discourage teen smoking.

Matt Myers, *executive vice-president of the National Campaign for Tobacco-Free Kids*

Myers strongly questioned the sincerity of the Philip Morris' new initiative, arguing, for example, that the company's alleged anti-smoking ads subtly encouraged teenagers to smoke.

Task force members also questioned the sincerity of the initiative, citing the company's strong opposition to past state legislation, such as the Clean Indoor Air Act. Task force members also pointed out that Philip Morris' $100 million national campaign to discourage smoking paled beside the nearly $6 billion the tobacco industry spends on advertising and promotions each year to encourage smoking. ■

"It's very important that we spend enough money over a long enough time to make a real difference in smoking by Vermonters."

– Participant at St. Albans Public Forum

What Vermonters Said at the Forums

Spend the Tobacco Money on Tobacco-Related Issues

The public resoundingly called for the new tobacco funds to be spent on tobacco-related issues. There was not a single voice raised in favor of spending the funds on a tax cut or for roads and bridges as is being done in other states.

Spend the Money on Prevention First

Spending the money on helping kids to not start to smoke would get the biggest return for the investment, the public said. There was some support for spending the funds on teen centers and skate board parks but always with the understanding that such efforts must help reduce smoking rates.

Cessation

In addition to the strong support for funding prevention, there was also strong support for helping adults and kids quit smoking. Many participants emphasized the importance of providing cessation support and medications, regardless of income level.

Trust Fund Investment

The public supported investing some of the funds into a permanent trust fund. However, some were concerned that postponing spending now will only prolong the damage tobacco causes in Vermont.

Different Communities: Different Needs

Task Force members heard different viewpoints and about different programs depending on the community.

Independent Board

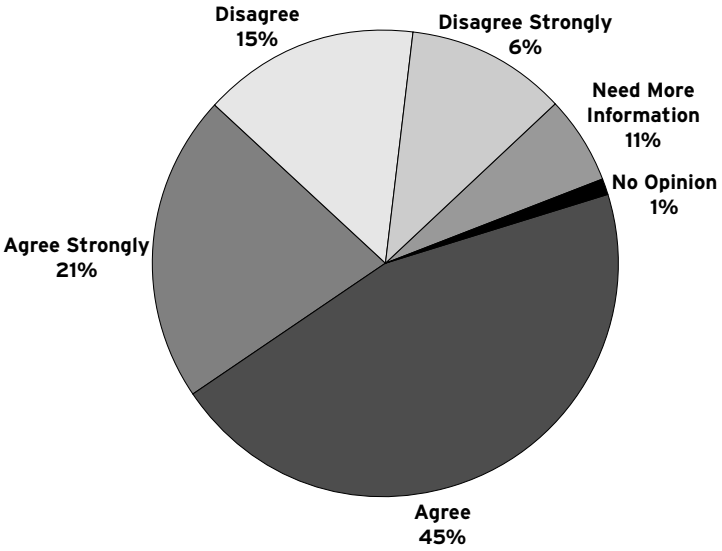
A majority of the public attending the forums expressed support for administering the funds through an independent board, free of political and tobacco influence.

(Transcripts of complete forum comments are available through the Legislative Council at the State House.)

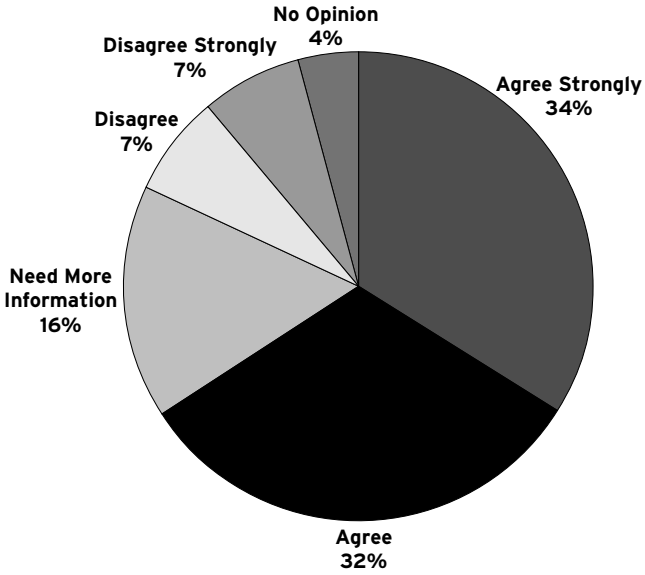
Summary of Forum Exit Survey

About 70 percent of the adult attendees, 248, filled out an exit survey.

Do you agree with the Task Force's recommendation to divide the funding equally between tobacco control efforts, a tobacco trust fund, and tobacco-related health care needs?

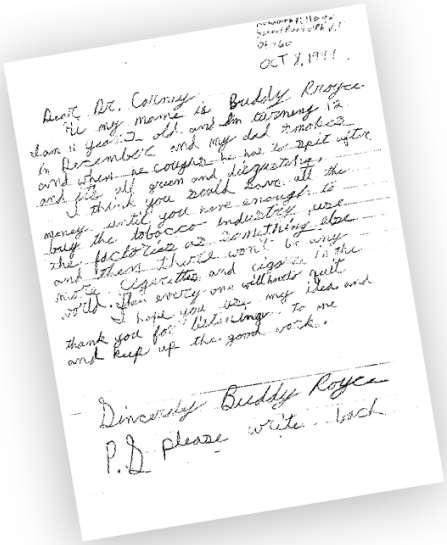


Do you agree with the Task Force's recommendation to create an independent board to administer the statewide program created through the tobacco funds?



Letters to the Task Force

Task Force members received about 75 letters and statements, either individually or through the Legislative Council, commenting on the task force plan and recommending programs. Included in the submissions were letters from the sixth grade class of Randolph Village School. Two letters are printed below.



Randolph Village School
Randolph, Vt. 05060
OCT 8, 1999

Dear Dr. Carney

Hi my name is Buddy Royce. I am 11 years old and I'm turning 12 in December and may dad smokes and when he coughs he has to spit after and it's all green and disgusting.

I think you sould save all the money until you have enough to buy the tobacco industry, use the factories as something else and then there won't be any more cigerettes and cigars in the world. Then every one will have to quit.

I hope you use my idea and thank you for listening to me and keep up the good work.

Sincerely Buddy Royce
P.S. Please write back.

Randolph Village School
Randolph, VT 05060

Dear Dr. Carney,

My name is Reiko Sakai. I'm in Nancy Reid's sixth grade class. I want to tell you my thoughts about cigarette smoking.

I am over-joyed that tobbaco companies are giving Vermont all this money. I am also glad that Vermont is going to spend it on such an urgent cause. It does make a lot of sense to me, even though I'm only ten years old, that almost the only people who start smoking are kids.

So, how can we change this? Well, first of all, the commercials for anti-smoking are a great idea. However, no offense to you or whoever designs those commercials, but I don't (think) they work as well as they should. Some are even laughed at.

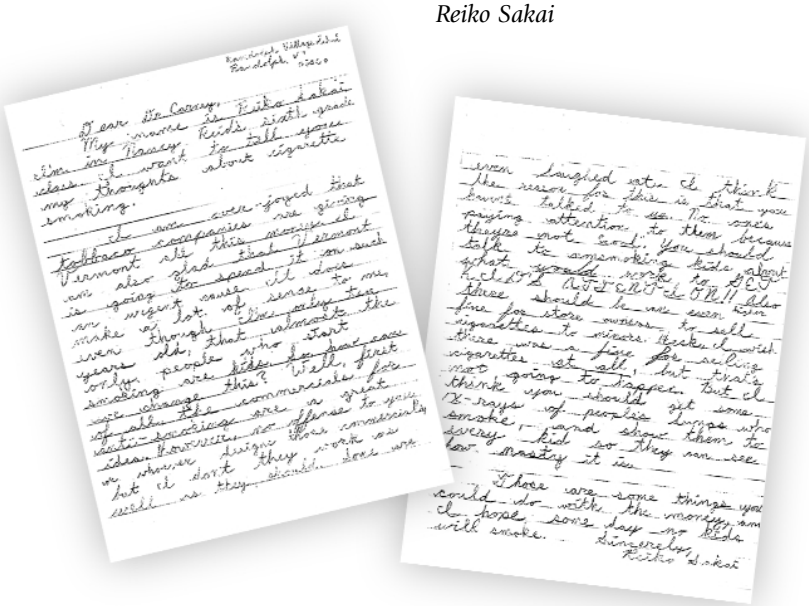
I think the reason for this is that you haven't talked to us. No one's paying attention to them because they're not "cool." You should talk to nonsmoking kids about what would work to GET KID'S ATTENTION!!

Also there should be an even higher fine for store owners to sell cigarettes to minors. Heck, I wish there was a fine for selling cigarettes at all, but that's not going to happen.

But I think you should get some x-rays of people's lungs who smoke, and show them to every kid so they can see how nasty it is.

Those are some things you could do with the money, and I hope some day no kids will smoke.

Sincerely,
Reiko Sakai



Appendix: The Master Settlement Agreement

For years, Big Tobacco has skillfully deflected and avoided federal, state and local regulatory efforts and promoted tobacco use by spending over $5 billion per year nationally on lobbying, advertising, and promotions. States, such as Vermont, have simply never had the budget or resources to fight back with comprehensive, long-term prevention and cessation programs.

All this changed in November 1998, when the Big Five tobacco companies agreed to settle a multi-billion dollar lawsuit brought by 46 states. Under the Master Settlement Agreement, the states will receive $206 billion over the next 25 years as compensation for the past harm and costs of tobacco use.

Vermont is scheduled to receive approximately $30 million per year over the next 25 years and to receive payments in perpetuity.

Tobacco companies started making payments in December 1998 into state specific escrow accounts. These payments will be released no later than June 20, 2000. The following sections provide a quick overview of the Master Settlement Agreement from national and Vermont perspectives.

This section then considers in more detail many of the provisions of the agreement and points out what the agreement does and doesn't do.

The section concludes with an overview of the federal government's recent lawsuit against the tobacco companies and what it might mean for Vermont.

National Perspective

On November 23, 1998, the Attorneys General and other representatives of 46 states, Puerto Rico, the U.S. Virgin Islands, American Samoa, the Northern Mariana Islands, Guam and the District of Columbia signed an agreement with the five largest tobacco manufacturers (Brown & Williamson Tobacco Corporation, Lorillard Tobacco Company, Philip Morris Incorporated, R.J. Reynolds Tobacco Company, Commonwealth Tobacco, and Liggett & Myers), ending a four-year legal battle between the states and the industry that began in 1994 when Mississippi became the first state to file suit.

The agreement settles all claims the states brought or could have brought against the tobacco companies based on any tobacco company action taken before the settlement. The settled claims not only include any claims for Medicaid reimbursements, but also all other civil claims (e.g., anti-trust, consumer protection, common law negligence) or statutory claims the states could have brought against the tobacco companies.

The agreement also settles all potential claims by the states against the tobacco companies based on the companies' future acts that pertain to the use of or exposure to tobacco products manufactured by the companies, including any claims for related health costs.

The agreement does not block traditional consumer protection, fraud, and anti-trust actions by the states.

The agreement covers all such claims by the state itself, but also covers any such claims by cities and counties or by citizens acting as private attorney generals pursuant to existing state laws.

This agreement cannot be modified in any way unless all the parties agree to the change.

Over the next 25 years, states will receive over $206 billion from the settlement. These funds will not be available to states until June 30, 2000.

There are provisions in the master settlement agreement that could reduce the states' payments. For example, they could be reduced if the federal government enacts a new tax on tobacco products and earmarks these funds for health care or gives them to the states on an unrestricted basis.

States would also lose a portion of their share if they fail to pass a model statute that is designed to protect the five major U.S. tobacco companies that are parties to the agreement from unfair competition by foreign and smaller companies that are not.

The tobacco settlement permits additional state legislation regarding youth access and environmental smoking. The settlement establishes eight areas of state legislation/regulation that the industry is prohibited from lobbying against.

Federal legislation is not required to implement the settlement agreement, however; federal legislation is needed to prevent the federal government from staking claim to more than half of the state's tobacco settlement dollars. Congress passed and the President signed legislation last spring pledging that the federal government would not claim any of the state settlement.

Source: National Association of Attorneys General and National Conference of State Legislatures

Vermont Perspective

Vermont has set aside one of the country's highest percentages of its tobacco settlement payments for tobacco programs. Under the terms of the 1998 multi-state settlement agreement, the tobacco industry will pay Vermont an initial amount of $9.9 million. Each year thereafter, Vermont will receive a payment between $26.4 and $34.5 million.

Beginning in 2008, Vermont will receive a "strategic contribution bonus" of $15 million per year for 10 years. This bonus rewards Vermont for its exemplary effort and contribution in the national effort against the tobacco industry.

The settlement stipulates that payments are to be made in perpetuity. Settlement payments will depend on several factors, such as the inflation rate and the volume of tobacco sales. The state should receive about $802 million in the next 25 years, based on a 3 percent upward adjustment for annual inflation and a 3.8 to 5.1 percent downward adjustment for reduced sales. *(See page 46 in the Appendix for the schedule.)*

Prior to the FY2000 appropriation of settlement funds, no Vermont state funds were directly allocated for tobacco prevention and cessation programs. Past programs were funded by federal and foundation grants.

The Vermont Legislature passed and Governor Howard Dean signed the state's FY 1999-2000 budget bill, which allocates $9.9 million of the FY1999 settlement payment and $9 million of the $26 million FY2000 payment to a fund dedicated exclusively for tobacco-control programs. The remainder of the money was allocated to other health programs.

Thus, the fund will have $18.9 million for tobacco prevention for FY 1999-2000. Actual appropriation of dollars from the fund is expected to take place in the spring of 2000.

The Legislature and Governor approved the creation of a Tobacco Control Task Force last spring and authorized it to spend $70,000 to develop a tobacco prevention plan.

The Governor and the Legislative appointed the 11-member Task Force. The members include two members of the House, two members of the Senate, the Commissioners of Health and Education, the Attorney General, a representative of low-income Vermonters, a representative from the advocacy community, a tobacco cessation expert, and a tobacco prevention expert.

Rep. Ann Seibert (Norwich) and Sen. Helen Riehle (Burlington) are chair and vice-chair of the task force.The Task Force was charged with developing a tobacco control plan by November 15.

The Vermont Legislature will appropriate money from the Tobacco Fund in the 2000 session based, in part, upon the plan presented by the Task Force.

Source: National Campaign for Tobacco-Free Kids and Vermont State Treasurer

"As the price of a pack of cigarettes continues to increase, more merchants may begin selling singles as a way to continue to make profits from adult and minor customers who can no longer afford and entire pack."

– Study by the Public Health Foundation

Provisions of the Master Settlement Agreement

Public Health/Youth Access

• Requires the industry to make a commitment to reducing youth access and consumption.

• Prohibits youth targeting in advertising, marketing and promotions.

• Bans cartoon characters in advertising;

• Restricts brand-name sponsorships of events with significant youth audiences.

• Bans outdoor advertising.

• Bans youth access to free samples.

• Sets minimum cigarette package size at 20 (sunsets 12/31/01).

The agreement still permits the following tobacco advertising and marketing practices:

• Permits outdoor advertising with signs of 14 square feet or smaller on the buildings or property of places where tobacco is sold (including stores near schools) and at events sponsored by the tobacco industry.

• Permits the use of human images in tobacco advertising, such as the Marlboro Man.

• Permits each tobacco company to continue a single tobacco brand-name sponsorship of auto racing, rodeo, or other event not specifically prohibited, with "single" sponsorships including the sponsorship of entire series of auto races, rodeos, or other events (e.g., all NASCAR races).

The agreement does state, however, that the tobacco companies cannot "take any action, directly or indirectly, to target youth in the advertising, promotion, or marketing of tobacco products." Whether this provision will have any impact on their behavior will depend on how vigorously it is enforced by the states' attorneys general and how it is interpreted by the courts.

Public Education and Research: The American Legacy Foundation

• The agreement requires that tobacco companies contribute $300 million a year for four years to a new national foundation that will create a public education program to reduce underage tobacco use and educate consumers about the causes and prevention of diseases associated with the use of tobacco products. This foundation, now called the American Legacy Foundation, may be funded at a rate of $300 million per year indefinitely.

• The agreement prohibits the legacy's public education funds from supporting ads that vilify the tobacco industry, any of its member companies, or any of its individual employees.

• The Foundation can fund grants to states that have ongoing and significant tobacco programs. These grants are still subject to the rule prohibiting vilification of the tobacco industry.

• The agreement also requires that the tobacco companies provide the national foundation with $25 million each year for 10 years to support research concerning tobacco use and other substance abuse. The foundation is to work with major research institutions to make most effective use of funds.

Changing Corporate Culture

Trade Associations. The agreement dissolves the Tobacco Institute, the Council on Tobacco Research, and the Center for Indoor Air Research, which have all served as propaganda tools of the tobacco industry. The agreement states that the Council on Tobacco Research may not be reconstituted, but the others may be reconstituted under rules set forth in the agreement designed to bring greater oversight to their activities.

Limits Tobacco Industry Efforts. The agreement prohibits any efforts by the tobacco industry to divert settlement payments to programs that are not tobacco or health-related.

Lobbying Restrictions. The agreement bars any efforts by the tobacco industry or their lobbyists to oppose eight specified kinds of new state or local tobacco-control legislation or administrative rules, which include measures to: 1) restrict youth access to vending machines; 2) include cigars in the definition of tobacco products; 3) enhance enforcement of laws forbidding sales of tobacco products to youth; 4) support the use of new technology to enforce age-of-purchase laws; 5) limit promotions of non-tobacco products that use tobacco products as prizes or giveaways; 6) enforce access restrictions through penalties on youth possession or use; 7) limit tobacco product advertising or the wearing of tobacco logo merchandise in or on school properties; and 8) limit non-tobacco products designed to look like tobacco products (e.g., candy cigarettes).

"Big tobacco spent $28.8 million in 1996 and $35.5 million in 1997 and employed 208 lobbyists to lobby Congress. That is one lobbyist for every 2.5 members of Congress."

– Public Citizen

Lobbying Disclosure Requirements The agreement requires that, in those states that do not already require tobacco companies to disclose their lobbying expenditures, the tobacco companies must periodically disclose any payment to a lobbyist if the state attorney so requests. This provision requires that a tobacco company disclose lobbying expenditures if the payment will be used to influence state or local legislation or governmental action pertaining to tobacco products or their use.

Document Disclosure The agreement requires that the tobacco industry documents, which have been produced in litigation and for which no claim of privilege has been made, be placed on the Internet, requires the tobacco industry to maintain the site for 10 years, and requires the industry to produce a detailed index to the documents. The agreement does not provide a process for challenging any industry claim of privilege that has not already been overturned by a court.

Enforcement

- Provides court jurisdiction for implementation and enforcement.
- Establishes a state enforcement fund ($50 million one-time payment).

Attorney Fees

- Funded separately from the $206 billion in payments to states
- Requires the industry to reimburse states for attorney fees (reimbursement will be based on the market rate in each state).
- Requires the industry to pay for outside counsel hired by the states.

Federal Issues Not Addressed

- Require more effective and more visible health warnings on tobacco products.
- Establish Food and Drug Administration authority over tobacco products.
- Restrict U.S. tobacco company marketing to youth overseas.
- Help U.S. tobacco farmers make the transition to other forms of income. ■

Federal Lawsuit Seeks Health Care Costs from Tobacco Companies

On September 22, 1999, the Department of Justice filed a civil lawsuit against the largest cigarette companies to recover the billions of dollars the federal government spends each year on smoking-related health care costs.

The complaint, filed in U.S. District Court in Washington, D.C., alleges that the cigarette companies have conspired since the 1950's to defraud and mislead the American public and to conceal information about the effects of smoking.

The defendants include Philip Morris Inc.; Philip Morris Companies; R.J. Reynolds Tobacco Co.; American Tobacco Co.; Brown & Williamson Tobacco Corp.; British-American Tobacco P.L.C.; British-American Tobacco (Investments) Ltd.; Lorillard Tobacco Co. Inc.; Liggett and Myers Inc.; The Council for Tobacco Research U.S.A. Inc.; and, the Tobacco Institute Inc.

These companies are responsible for payments to the 46 states under the Master Settlement Agreement and to the four states that settled separately.

The federal suit, like the states' suit, alleges that the tobacco companies knowingly understated the harmful consequences of smoking.

• Made false and misleading statements to create a false controversy about whether smoking causes disease, even though they knew that smoking did cause disease.

• Sponsored research that was designed not to answer the question of whether smoking caused disease, promoted biased research that would assist in defending lawsuits brought by injured smokers, and suppressed research that suggested that smoking causes disease.

• Denied that nicotine was addictive, despite the fact that they knew nicotine was addictive.

• Denied that they marketed and/or targeted products to children, although they actively sought to capture the youth market.

The lawsuit is similar to those filed, and settled, by the states for more than $200 billion. While the state suits recovered funds paid out under the Medicaid program—a joint state and federal program—it did not recover funds paid out under solely federal programs such as Medicare. The federal government spends more than $20 billion per year to treat smoking-related diseases.

Impact on Vermont

State lawsuits and payments are separate and distinct from the federal lawsuit and the National Association of Attorneys General doesn't believe that the federal suit will affect payments to the states.

State lawsuits resolved state claims. The federal lawsuit would resolve federal claims and a judgment in a federal lawsuit would not abrogate the tobacco companies' responsibility to make payments to the states under the Master Settlement Agreement. ■

Sources: U.S. Department of Justice and National Association of Attorneys General

Highlights of Vermont Tobacco Programs

Legislation

1988

• **Smoking in the Workplace Law:** Requires all employers to establish a smoking policy. Policy must either prohibit smoking throughout the workplace or restrict smoking to designated enclosed smoking areas.

1991

• **Youth Access to Tobacco Products Law:** Legislature passes first youth access to tobacco law: sets 18 as minimum age for sale; requires retailers be licensed to sell tobacco; limits tobacco vending machines to places inaccessible to children; sets penalties for selling or furnishing tobacco products to people under age 18 and establishes penalties for people under 18 who misrepresent their age to purchase tobacco products.

1993

• **Smoking in Public Places Law/Clean Indoor Air Act** passed. Prohibits the possession of lighted tobacco products in the common areas of enclosed indoor spaces that are accessible to the public and in publicly owned businesses and offices. Only businesses issued a cabaret license may have smoking areas. Restaurant ban went into effect July 1, 1995

1995

• **Tobacco Use on Public School Grounds Law**. Prohibits people from using tobacco on public school grounds and makes it unlawful for students to use tobacco at school-sponsored functions.

• **Health Care Financing Law.** State cigarette tax raised to $0.44 from 20 cents; tobacco products tax increased from 20 to 41 percent of the wholesale price. Taxes fund Vermont's Health Access Program.

1997

• **Youth Access to Tobacco Law** bans tobacco self-service displays and vending machines; directs DLC to conduct compliance checks to secure a minimum 90 percent compliance rate of not selling tobacco products to minors; mandates license suspension for second and subsequent sale to a minor; makes possession of tobacco by a minor a civil offense.

• **Attorney General and Commissioner of Health file suit against the tobacco industry**

1998

• **Attorney General announces Master Settlement Agreement** with tobacco industry. Vermont to receive an estimated $30 million per year for 25 years.

Funding

There were no state or federal programs during most of the 1990s that were specifically targeted or sufficiently funded to develop a comprehensive tobacco control program.

From 1989-93, the Vermont Department of Health's Office of Health Promotion addressed tobacco use through efforts such as the Heart Healthy Vermonters initiative, which provided small grants to local communities for health-related programs, and "Quit and Win," which used donated prizes, such as trips, to reward people who stopped smoking.

In the mid-1990s, the Department of Health began targeting approximately $100,000 to $200,000 a year, consisting of federal and foundation grants, toward tobacco prevention and cessation programs. Since fiscal year 1994, the Department of Health has provided staff support from its district offices for a smoking cessation program for pregnant women run by UVM's Office of Health Promotion Research. UVM has received about $350,000 from the federal Women, Infant, and Children's Program to develop and support a peer counseling telephone network around the state.

During the early 1990s, the Department of Health's Office of Alcohol and Drug Abuse programs viewed tobacco as an addictive substance. The office supported some generic prevention and cessation strategies that were useful to smokers, but tobacco was not a specific target.

Only since fiscal year 1999, when federal and foundation grants totaled more than $460,000, has Vermont received significant funding for tobacco issues.

In 1999 a Centers for Disease Control and Prevention (CDC) one-year grant of $750,000 will support the hiring of five people and the creation of a separate Tobacco Office in the Department of Health. The grant is renewable for four years and will total about $3.5 million.

With the annual payment from the Master Settlement Agreement, Vermont will be able to support a comprehensive tobacco prevention and cessation program in line with recommendations from the CDC. The Center estimates a comprehensive program would cost between $7.9 million and $15.9 million annually. ■

Acknowledgements

The Task Force extends its sincere appreciation to all the people who helped the Task Force this summer and fall. In particular, the Task Force wished to recognize the many volunteer facilitators who helped with the forums; the professional facilitators provided by the Vermont Prevention Institute Center; the schools in Brattleboro, St. Albans, Rutland, Barre, Windsor, St. Johnsbury, and Burlington that provided space; Futura Design of Shelburne, Vt.; and the Vermont-based consultant team of Richard Watts, George Bellerose, Diane Meyerhoff, Susan Minter, Jennifer Wallace-Brodeur and Jeanne Kirby that coordinated the public forums and the final report; and the many Vermonters who listened and gave their advice.