MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

2380

2001 SENATE HUMAN SERVICES

SB 2380

2001 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2380

Senate Human Services Committee

❑ Conference Committee

Hearing Date January 31, 2001

Tape Number	Side A	Side B	Meter #
1		X	23.1
2	X		
February 12, 2001 1	X		6
February 13, 2001	X		
Committee Clerk Signature	Carol Kolodjeski		

Minutes:

The hearing was opened on SB 2380.

SENATOR RAY HOLMBERG introduced the bill. (Written testimony) SENATOR MATHERN: Are you open to changing general formula to all needs? SENATOR HOLMBERG: We are not proposing to change settlement agreement. Last time we decided 10%. SENATOR KILZER: Considerable information came from health department. Did you use those or stay with CSG? SENATOR HOLMBERG: There were many suggestions, but it is essentially CSG. The goal of the sponsors is to try to solve this problem; no, I said that wrong, we can't solve the problem, but we can make a difference, I believe.

SENATOR HEIDKAMP, cosponsor, supports the bill, but realizes amendments are forthcoming. This is a bill of work in progress. We are dealing with it. It is unacceptable for the realization of teenage smoking on the rise. There is lots of activity in other states also.

LOIS DELMORE, cosponsor of the bill, supports the bill.

SENATOR MATHERN: Would you open to Tribes being included in bill? SENATOR HEITAMP: Yes, they should be in there. A huge part of where the problem is. There is a requirement of one of the members coming from the Reservation.

SENATOR ANDRIST, cosponsor of the bill, supports bill. Offers amendments, written testimony.

SENATOR KILZER: Did you stack it up against the Washington program. SENATOR ANDRIST: The program in Massachusetts has claimed success. SENATOR MATHERN: Comments of changing qualifications of committee members. Should we restrict people that are supportive of the tobacco industry. SENATOR ANDRIST: The Governor is to pick the most appropriate people.

HEIDI HEITKAMP, former Attorney General, gives the bill only lukewarm support. It doesn't go far enough. Older people have interest also. Maybe it should read Tobacco Control. Think beyond the use by just young people. The money was about long term, fraudulent, and falsehoods that were told about tobacco being good for your health. This is Antitrust, not Medicaid. To compensate the fraud that was done. Money was about tobacco health. You will get slightly less than $100 million. Have not funded 10% of tobacco funds. Do the programs work: Read article about successful programs in other states. Flexibility will lead to anti drug, alcohol, as well. SENATOR MATHERN: Can you help us clarify the $10 million; have some evidence to look at the bigger picture. MS. HEITKAMP: Payments come in two forms to ND: initial payments which is 5 years of payments that are already in place and adjusted and the amount is specified in the agreement less volume adjustments and adjustments for loss of market shares. This has happened because people have been running successful anti-tobacco programs, not only with money, but restricting where you can smoke. The other portion of the payment is

the annual payment which comes in April 15 and that is adjusted for inflation upward 3% . At a minimum you will have a 3% adjustment you receive in April and then you have a volume adjustment as the cigarette consumption goes down. Realize that this is based on National consumption and if ND doesn't respond to this problem ND will not get the resources to address it.

GLENN THOM, American Heart Association, supports this bill. (Written testimony) Testimony of June Herman.

SANDRA ADAMS, Dept of Health, is offering comments (Written testimony) SENATOR MATHERN: Why don't you recommend the allocation of 10 million? MR. BARNESS: The initial 5 million would stay on - in the department funds - to provide the cash flow for these programs. We do believe that by 6/30/03 the 10 Million will be available. SENATOR KILZER: Do the Health Dept and DPI both have programs in place. Do they coordinate between each other and if we were to add a third commission would they all work together. MS. ADAMS: Yes, currently we coordinate to funnel dollars. We have state wide conferences that bring in the whole state. Our proposal is to have a state wide advisory committee to funnel dollars together.

LINDA JOHNSON, Director of School Health Programs, provided information on the school tobacco prevention programs in ND. (Written testimony)

SUSAN BOSAK, Meritcare Health System, supports bill, (Written testimony) SENATOR LEE commented that in all the testimony there is talk of Government help. Where is the personal responsibility? They want the Government to do it to them.

SUSAN KAHLER, American Lung Association, supports bill. (Written testimony)

BRUCE LEVI, ND Medical Assoc, supports bill. (Written testimony) Proposed amendments.

SENATOR MATHERN: You raised the question of the future in tobacco prevention. MR. LEVI: 2380 sets up a structure to develop a hierarchy- subject to ongoing changes in the future.

The hearing was closed on SB 2380.

February 12, 2001, Tape 1, Side A, Meter 6.0

Discussion resumed on SB 2380. Amendments were presented by Senator Mathern. It would change from youth smoking to tobacco to broaden usage group. The committee would include the Attorney General, Native Americans, youth for priority programs. 30% off the top of the fund they divide 45% for Health, 45% for schools, 10% for water. Discussion. SENATOR MATHERN moved the amendments with line 15 page 1 to line 15, page 2. SENATOR POLOVITZ seconded the motion. Roll call vote carried 5-1. SENATOR FISCHER moved to further amend by deleting Section 12 of the amendments. SENATOR ERBELE seconded the motion. Discussion. Roll call vote carried 5-1. Discussion continued. DARLENE BARTZ appeared stating they would bring recommendations on appropriations and CDC recommendation. 70% in grants, 10% statewide media, 10% surveillance, 10% personnel training and supplies. More discussion ensued.

SENATOR MATHERN introduced his wife, LOREEN. They are celebrating their 30th wedding anniversary today.

The discussion led to drafting additional amendments with CDC plug in from the Governor's office amendments and to include funding for Fargo Community Health Center. Should we change the Commission to Advisory Board? SENATOR KILZER move the amendment to change Commission to Advisory Board and tidy up language accordingly. SENATOR POLOVITZ seconded the motion. Roll call vote carried 5-1. In studying Lieutenant Governor

Dalrymple's amendments, SENATOR FISCHER moved to delete lines 24 and 25, page 5. SENATOR KILZER seconded the motion. Voice vote carried. Discussion. SENATOR FISCHER moved to amend section 11, c,d,e,f, to start with "Not to exceed". SENATOR ERBELE seconded the motion. Roll call vote carried 5-1. Discussion. SENATOR MATHERN moved the amendment on Line 26, page 7, Federal dollars and any other moneys that would be the sum of $10,476,110 but limited to funds already received. SENATOR ERBELE seconded the motion. Roll call vote failed 2-4. SENATOR MATHERN moved the same motion changing the amount to $7,400,000. Roll call vote carried 6-0. SENATOR FISCHER moved amendment g, $500,000 to Fargo Community Health Center. SENATOR MATHERN seconded the motion. Voice vote carried.

February 13, 2001, Tape 1, Side A.

The committee was called to order by SENATOR LEE. All Senators were present.

Discussion resumed on SB 2380.

The draft of the engrossed bill was reviewed. In section 4 delete the phrase "subject to the committee's control". Section 3, change committee to State Health Officer. Section 9, delete. Switch section 3 & 4 in location. Section 12, $7,600,000. SENATOR FISCHER moved the amendments. SENATOR KILZER seconded it. Roll call vote carried 6-0 SENATOR MATHERN moved a DO PASS and REREFER to Appropriations. SENATOR KILZER seconded the motion. Roll Call vote carried 6-0. SENATOR LEE will carry the bill.

FISCAL NOTE

Requested by Legislative Council
04/20/2001

Bill/Resolution No.:

Amendment to: Reengrossed SB 2380

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	1999-2001 Biennium		2001-2003 Biennium		2003-2005 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures				$350,000		
Appropriations				$350,000		

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

1999-2001 Biennium			2001-2003 Biennium			2003-2005 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

This bill pro· es for a community health trust fund advisory committee of 11 members to be established to advise the state department of health regarding the community health grant program. Section 4 provides an appropriation for this advisory committee of $100,000 per biennium from the community health trust fund. This would include all meeting costs, reports, reviews, and recommendations completed by this committee. Section 5 of this bill provides an appropriation of $250,000 from the community health trust fund to the state department of health for the purpose of funding grants to cities and counties on a dollar-to-dollar matching fund basis for city and county employee tobacco education and cessatin programs.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The state department of health anticipates the entire $350,000 would be expended during the 2001-2003 biennium to carry out the activities identified in Sections 4 and 5 as identified in the above narrative.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect*

on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.

The state department of health does not currently have the appropriation for the $350,000 addressed in sections 4 and 5 of this bill incuded in it's appropriation bill SB 2004.

Name:	Kathy J. Albin	**Agency:**	Department of Health
Phone Number:	328-2392	**Date Prepared:**	04/23/2001

FISCAL NOTE

Requested by Legislative Council
04/04/2001

Bill/Resolution No.:

Amendment to: Reengrossed SB 2380

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	1999-2001 Biennium		2001-2003 Biennium		2003-2005 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures				$350,000		
Appropriations				$350,000		

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

1999-2001 Biennium			2001-2003 Biennium			2003-2005 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

This bill provides for a community health trust fund advisory committee of 11 members to be established to advise the state department of health regarding the community health grant program. Section 3 provides an appropriation for this advisory committee of $100,000 per biennium from the community health trust fund. This would include all meeting costs, reports, reviews, and recommendations completed by this committee. Section 4 of this bill provides an appropriation of $250,000 from the community health trust fund to the state department of health for the purpose of funding grants to cities and counties on a dollar-to dollar matching fund basis for city and county employee tobacco education and cessation programs.

It is assumed that the appropriation for the community health trust fund will be appropriated in SB 2004.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The state department of health anticipates the entire $350,000 would be expended during the 2001-2003 biennium to carry out the activities identified in Sections 3 and 4 as identified in the above narrative.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

The state department of health does not currently have the appropriation for the $350,000 addressed in sections 3 and 4 of this bill and would need it added to the department's appropriation.

Name:	Kathy J. Albin	**Agency:**	Department of Health
Phone Number:	328-2392	**Date Prepared:**	04/05/2001

FISCAL NOTE

Requested by Legislative Council
03/29/2001

REVISION

Bill/Resolution No.:

Amendment to: Reengrossed SB 2380

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	1999-2001 Biennium		2001-2003 Biennium		2003-2005 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues			($400,000)	$400,000		
Expenditures				$350,000		
Appropriations				$350,000		

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

1999-2001 Biennium			2001-2003 Biennium			2003-2005 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

This bill provides for a community health trust fund advisory committee of 11 members to be established to advise the state department of health regarding the community health grant program. Section 4 provides an appropriation for this advisory committee of $100,000 per biennium from the community health trust fund. This would include all meeting costs, reports, reviews, and recommendations completed by this committee.

Section 5 of this bill provides an appropriation of $250,000 from the community health trust fund to the state department of health for the purpose of funding grants to cities and counties on a dollar-to dollar matching fund basis for city and county employee tobacco education and cessation programs.

It is assumed that the appropriation for the community health trust fund will be appropriated in SB 2004 which is currently being heard by the House HR subcommitee.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The amendments to this bill will allow the interest earned on the community health trust fund to remain in the fund and may be used by the state department of health.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The state department of health anticipates the entire $350,000 would be expended during the 2001-2003 biennium to carry out the activities identified in Sections 4 and 5 as identified in the above narrative.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

The state department of health does not currently have the appropriation for the $350,000 addressed in sections 4 and 5 of this bill and would need it added to the department's appropriation.

Name:	Kathy J. Albin	**Agency:**	State Department of Health
Phone Number:	328-2392	**Date Prepared:**	03/28/2001

FISCAL NOTE

Requested by Legislative Council
03/28/2001

Bill/Resolution No.:

Amendment to: Reengrossed SB 2380

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	1999-2001 Biennium		2001-2003 Biennium		2003-2005 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$350,000		
Expenditures				$350,000		
Appropriations				$350,000		

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

1999-2001 Biennium			2001-2003 Biennium			2003-2005 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

This bill provides for a community health trust fund advisory committee of 11 members to be established to advise the state department of health regarding the community health grant program. Section 4 provides an appropriation for this advisory committee of $100,000 per biennium from the community health trust fund. This would include all meeting costs, reports, reviews, and recommendations completed by this committee.

Section 5 of this bill provides an appropriation of $250,000 from the community health trust fund to the state department of health for the purpose of funding grants to cities and counties on a dollar-to dollar matching fund basis for city and county employee tobacco education and cessation programs.

It is assumed that the appropriation for the community health trust fund will be appropriated in SB 2004 which is currently being heard by the House HR subcommitee.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

There is a need for the state department of health to receive revenue of $350,000 in order to carry out the activities identified in Section 4 and 5 as identified in the above narrative.

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The state department of health anticipates the entire $350,000 would be expended during the 2001-2003 biennium to carry out the activities identified in Sections 4 and 5 as identified in the above narrative.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

The state department of health does not currently have the appropriation for the $350,000 addressed in sections 4 and 5 of this bill and would need it added to the department's appropriation.

Name:	Kathy J. Albin	**Agency:**	State Department of Health
Phone Number:	328-2392	**Date Prepared:**	03/28/2001

FISCAL NOTE

Requested by Legislative Council
02/21/2001

Bill/Resolution No.:

Amendment to: Engrossed SB 2380

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	1999-2001 Biennium		2001-2003 Biennium		2003-2005 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$0		
Expenditures				$0		
Appropriations				$0		

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

1999-2001 Biennium			2001-2003 Biennium			2003-2005 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

This bill provides for a tobacco prevention advisory committee established in the office of the governor. The committee would be made up of 12 members. The purpose of the committee would be to develop a state plan for tobacco prevention and dependency treatment which is built on and does not duplicate the existing CDC tobacco grant requirements. The committee would also provide grants for tobacco prevention programs and according to section 9 of this bill. **A new line item for tobacco prevention and control was created in the Health Department's appropriation bill SB 2004. This includes funding from the community health trust fund of $4,700,000 and federal funds from CDC of $2,369,934 for a total of $7,069,934 to implement the programs outlined in this bill.**

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the*

executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.

Name:	Kathy J. Albin	**Agency:**	Department of Health
Phone Number:	328-2392	**Date Prepared:**	03/05/2001

FISCAL NOTE

Requested by Legislative Council
02/14/2001

Bill/Resolution No.:

Amendment to: SB 2380

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law*

	1999-2001 Biennium		2001-2003 Biennium		2003-2005 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$7,600,000		
Expenditures				$7,600,000		
Appropriations				$7,600,000		

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

1999-2001 Biennium			2001-2003 Biennium			2003-2005 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

This bill provides for a tobacco prevention advisory committee established in the office of the governor. The committee would be made up of 12 members. The purpose of the committee would be to develop a state plan for tobacco prevention and dependency treatment. The committee would also provide grants for tobacco prevention programs, and according to section 10 of this bill.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The revenue included in this fiscal note would be from the community health trust fund and other funds derived from federal funds and from other income.

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Section 11 of this bill provides an appropriation of $7.6 million to carry out the provisions of the bill. The funds will be used to defray costs of the tobacco prevention committee and for providing grants for tobacco prevention activities and those programs identified in section 10.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

This bill provides an appropriation from the community health trust fund in the amount of $7.6 million to the State Departtment of Health

Name:	Kathy J. Albin	**Agency:**	Department of Health
Phone Number:	328-2392	**Date Prepared:**	02/15/2001

FISCAL NOTE

Requested by Legislative Council
01/29/2001

Bill/Resolution No.: SB 2380

Amendment to:

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	1999-2001 Biennium		2001-2003 Biennium		2003-2005 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$5,200,000		
Expenditures				$5,200,000		
Appropriations				$5,200,000		

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

1999-2001 Biennium			2001-2003 Biennium			2003-2005 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

This bill provides for a youth smoking prevention commission established in the office of the governor. The commission would be made up of 13 members of which 10 would be appointed by the governor. The purpose of the commission would be to develop a state plan for youth smoking prevention. The commission would also establish and implement a treatment plan. The commission would also provide grants for youth smoking prevention programs.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The revenue included in this fiscal note would be from the community health trust fund.

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Section 11 of this bill provides an appropriation of $5.2 million to carry out the provisions of the bill. The funds will be used to defray costs of the youth smoking prevention commission and for providing grants for qualified youth smoking prevention programs.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the*

executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.

This bill provides an appropriation from the community health trust fund in the amount of $5,200,000 to the State Department of Health.

Name:	Kathy J. Albin	**Agency:**	Health Department
Phone Number:	328-2392	**Date Prepared:**	01/30/2001

ROUGH DRAFT

00793.0000
Title.

Prepared by the Legislative Council staff for

February 12, 2001

PROPOSED AMENDMENTS TO SENATE BILL NO. 2380

Page 7, after line 24, insert:

"**SECTION 11. AMENDMENT.** Subsection 1 of section 54-27-25 of the 1999 Supplement to the North Dakota Century Code is amended and reenacted as follows:

1. Transfers to a community health trust fund to be administered by the state department of health. ~~The state department of health may use funds as appropriated for community-based public health programs and other public health programs, including programs with emphasis on preventing or reducing tobacco usage in this state.~~ Transfers under this subsection must equal ten percent of total annual transfers from the tobacco settlement trust fund. Of the funds appropriated to the state department of health from the community health trust fund:

   a. The first one million dollars must be used by the department for public health emergencies and to provide funding for the grant programs established under this subsection, if necessary, based upon the anticipated timing of transfers to be received from the tobacco settlement trust fund.

   b. One million dollars must be used to provide state aid to local public health units.

   c. Two million dollars must be used to fund a healthy schools grant program that provides grants to schools for preventive health programs.

   d. Two million dollars must be used to fund a healthy communities grant program. The eligibility criteria for the program must include a one hundred percent matching funds requirement and must provide that grant eligibility is based upon a community's effectiveness in enforcing state and local tobacco seller and use laws and ordinances.

   e. Seven hundred fifty thousand dollars must be used to fund a statewide tobacco counter marketing media program.

   f. Two hundred fifty thousand dollars must be used to provide antitobacco materials and resources to the public."

Renumber accordingly

A BILL for an Act to establish a community health grant program; to provide an appropriation for the community health grant program; and to provide an appropriation for grants to community clinics.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Community health grant program. The state department of health shall establish a community health grant program that emphasizes preventing or reducing tobacco usage in this state.

1. Forty percent of all funds appropriated for the program shall be granted to public health units that have an agreement with school boards, developed with student participation, concerning the preventive health programs to be funded. The agreement must include a plan to reduce tobacco use by students, but the plan may include other preventive health programs.
2. Forty percent of all funds appropriated for the program shall be granted to public health units that have established a unit-wide plan concerning the preventive health programs to be funded. The plan must address programs to reduce tobacco use by the residents living in the counties served by the units, but the plan may include other preventive health programs.
3. Twenty percent of all funds appropriated for the program shall be granted to public health units to supplement state aid from other sources. Each unit shall receive one percent of the amount allocated pursuant to this subsection for each county within the unit and the remaining amount shall be distributed to each unit on a per capita basis.

SECTION 2. APPROPRIATION. There is appropriated out of any moneys in the community health trust fund, not otherwise appropriated, the sum of $5,000,000, or so much of the sum as may be necessary, to the state department of health for the purpose of funding the community health grant program provided for in section 1 of this Act, for the biennium beginning July 1, 2001, and ending June 30, 2003.

SECTION 3. APPROPRIATION. There is appropriated out of any moneys in the community health trust fund, not otherwise appropriated, the sum of $1,000,000, or so much of the sum as may be necessary, to the state department of health for the purpose of providing grants for primary health care to community clinics offering a sliding fee scale and demonstrating a commitment to serve a disproportionate share of low-income, uninsured, and underserved populations in both rural and urban North Dakota for the biennium beginning July 1, 2001, and ending June 30, 2003.

CONT

NEXT FICHE

e. One physician appointed by the North Dakota medical association.

2. Members of the committee who are not state employees or officers are entitled to be compensated at a rate of sixty-two dollars and fifty cents per day and are entitled to mileage and expenses as provided by law for state officers and employees. A state employee who is a member of the committee must receive that employee's regular salary and is entitled to mileage and expenses, to be paid by the employing agency.

3. The state department of health, with the committee's involvement, shall provide assistance to:

   a. Evaluate programs;

   b. Promote media advocacy by working with statewide media associations;

   c. Implement smoke-free policies by involving antitobacco groups in promoting the need for smoke-free public buildings;

   d. Work to reduce minors' access to tobacco in all communities;

   e. Facilitate the coordination of program components with the local level; and

   f. Involve state agencies, law enforcement, and local government in the administration and management of the program.

4. The state health officer shall monitor the implementation of the community health grant program. The state health officer shall provide reports to the legislative council regarding the implementation of the program not later than December 31, 2001, and November 1, 2002. Upon request, the state health officer shall provide assistance to any interim legislative committee that may study the implementation of the community health grant program and shall recommend any legislation that the community health grant program advisory committee considers appropriate to improve the community health grant program.

SECTION 3. APPROPRIATION. There is appropriated out of any moneys in the community health trust fund, not otherwise appropriated, the sum of $100,000, or so much of the sum as may be necessary, to the state department of health for the purpose of funding the community health grant program advisory committee, for the biennium beginning July 1, 2001, and ending June 30, 2003.

SECTION 4. APPROPRIATION. There is appropriated out of any moneys in the community health trust fund, not otherwise appropriated, the sum of $250,000, or so much of the sum as may be necessary, to the state department of health for the purpose of funding grants to cities and counties on a dollar-for-dollar matching fund basis for city and county employee tobacco education and cessation programs, for the biennium beginning July 1, 2001, and ending June 30, 2003.

SECTION 5. ALCOHOL, TOBACCO, AND DRUG ABUSE PROGRAMS - LEGISLATIVE COUNCIL STUDY. During the 2001-02 interim, the legislative council shall consider studying the programs that deal with the prevention and treatment of alcohol, tobacco, and drug abuse and other kinds of risk-associated behavior which are operated by various state agencies, including the department of corrections and rehabilitation, the attorney general, the state department of health, the department of human services, the department of public instruction, the department of transportation, the national guard, and the supreme court, and whether better coordination among the programs within those agencies may lead to a more effective and cost-efficient way of

operating the programs and providing services. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the fifty-eighth legislative assembly."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

Dept. 301 - State Department of Health - House Action

The bill as amended establishes a community health grant program, allocates moneys appropriated for the program, establishes a community health grant program advisory committee, provides appropriations from the community health trust fund of $100,000 for the expenses of the committee and $250,000 for matching grants to cities and counties for city and county employee tobacco education and cessation programs, and provides for a Legislative Council study of alcohol, tobacco, and drug abuse programs. The provision to allow the community health trust fund to retain any interest earned is removed.

Date: 3-30-01
Roll Call Vote #: 2

2001 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2380

House APPROPRIATIONS Committee

☐ Subcommittee on

or

☐ Conference Committee

Legislative Council Amendment Number 10732.0706

Action Taken Do Pass As Amended.

Motion Made By Rep Skarphol Seconded By Rep Delzer

Representatives	Yes	No	Representatives	Yes	No
Timm - Chairman	✓				
Wald - Vice Chairman	✓				
Rep - Aarsvold		✓	Rep - Koppelman		
Rep - Boehm	✓		Rep - Martinson	✓	
Rep - Byerly	✓		Rep - Monson	✓	
Rep - Carlisle	✓		Rep - Skarphol	✓	
Rep - Delzer	✓		Rep - Svedjan	✓	
Rep - Glassheim		✓	Rep - Thoreson	✓	
Rep - Gulleson		✓	Rep - Warner		✓
Rep - Huether		✓	Rep - Wentz	✓	
Rep - Kempenich					
Rep - Kerzman		✓			
Rep - Klinisky	✓				

Total (Yes) 13 No 6

Absent 2

Floor Assignment Rep Delzer

If the vote is on an amendment, briefly indicate intent:

Page 34, line 20, remove "tourism."

Page 35, line 3, remove "tourism and"

Page 35, line 17, remove "and tourism"

Page 38, line 5, overstrike "hereby"

Page 38, line 6, overstrike "which" and insert immediately thereafter "that"

Page 38, line 8, overstrike "and it" and insert immediately thereafter ". The council" and overstrike the second "shall"

Page 38, line 9, overstrike "consist" and insert immediately thereafter "consists" and after "of" insert "a traffic counsel selected by the members of the council, a representative of the railways serving the state who is selected by the council, and"

Page 38, line 14, overstrike "livestock industry council" and insert immediately thereafter "North Dakota stockmen's association"

Page 38, line 15, after "Dakota" insert "state"

Page 38, line 18, overstrike "farmers"

Page 38, line 19, overstrike "The North Dakota railway lines."

Page 38, line 20, overstrike "10."

Page 38, line 21, overstrike "11." and insert immediately thereafter "10."

Page 38, overstrike lines 22 and 23

Page 40, remove lines 15 through 19

Page 40, after line 21, insert:

"**SECTION 51. LEGISLATIVE COUNCIL CORRECTION OF STATUTORY REFERENCES.** The legislative council may replace references to the "department of economic development and finance", "division of community services", and "department of economic development and finance division of finance" with references to the "department of commerce division of economic development and finance", department of commerce division of community services", "department of commerce division of economic development and finance finance office", "department of commerce", and "commissioner of commerce", or any variation of these terms as appropriate, in any measure enacted by the fifty-seventh legislative assembly."

Page 40, line 23, replace the first comma with "and" and remove ", and"

Page 40, line 24, remove "tourism department"

Renumber accordingly

The reports of the majority and the minority were placed on the Seventh order of business on the calendar for the succeeding legislative day.

REPORT OF STANDING COMMITTEE

SB 2362, as engrossed: Appropriations Committee (Rep. Timm, Chairman) recommends DO PASS (17 YEAS, 4 NAYS, 0 ABSENT AND NOT VOTING). Engrossed SB 2362 was placed on the Fourteenth order on the calendar.

REPORT OF STANDING COMMITTEE

SB 2360, as reengrossed: Appropriations Committee (Rep. Timm, Chairman) recommends AMENDMENTS AS FOLLOWS and when so amended, recommends DO PASS (13 YEAS, 6 NAYS, 2 ABSENT AND NOT VOTING). Reengrossed SB 2360 was placed on the Sixth order on the calendar.

In lieu of the amendments adopted by the House as printed on pages 1124-1127 of the House Journal, Reengrossed Senate Bill No. 2360 is amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a community health grant program; to provide an appropriation; and to provide for a legislative council study.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Community health grant program.

1. The state department of health shall establish a community health grant program. The primary purpose of the program is to prevent or reduce tobacco usage in the state by strengthening community-based public health programs and by providing assistance to public health units and communities throughout the state. The program must build on and may not duplicate existing programs. Grants awarded under the program must be awarded on a noncompetitive basis using the per capita formula provided for in this subsection. The program must, to the extent funding is available, follow guidelines concerning tobacco prevention programs recommended by the centers for disease control and prevention. Entities awarded grants under the program may contract with or award grants to private providers that conduct tobacco cessation programs. Not more than five percent of the community health grant program funds may be expended for surveillance and evaluation activities. Funds appropriated for the program must be allocated as follows:

   a. Forty percent of all funds appropriated for the program must be granted to a public health unit or to cooperating public health units that have an agreement with school boards concerning preventive health programs to be funded. The program must be developed with student participation and must include a plan to reduce student tobacco use.

   b. Forty percent of all funds appropriated for the program must be granted to a public health unit or to cooperating public health units that have established a unitwide plan, developed in cooperation with local elected officials in the unit's jurisdiction, concerning the preventive health programs to be funded. The plan must address programs to reduce tobacco use by the residents living in the counties serviced by the units; however, the plan may include other chronic disease programs. In addition to any grants received under this subdivision, each county with a population of less than ten thousand must receive five thousand dollars per biennium to be used to implement the county's programs.

   c. Twenty percent of all funds appropriated for the program must be granted to public health units to supplement existing state aid from other sources. Each unit must receive one percent of the amount allocated under this subsection for each county within the unit and the remaining amount must be distributed to each unit on a per capita basis.

2. The state department of health, in establishing the community health grant program, shall build upon the state's existing tobacco control grant program activities and shall follow the centers for disease control and prevention's best practices for comprehensive tobacco control programs. The department shall encourage applicants to include in their plans:

   a. Community programs that:

      (1) Engage youth in the development and implementation of interventions;

      (2) Develop partnerships with local organizations;

      (3) Conduct educational programs at local levels; and

      (4) Promote government and voluntary health policies, such as clean indoor air, youth access, and treatment coverage.

b. Promotion of school programs by partnering with public health organizations, school boards, education associations, and other organizations in each county to provide school programs that promote:

(1) Tobacco-free policies;

(2) Evidence-based curricula;

(3) Teacher training;

(4) Parental involvement; and

(5) Cessation services for students and staff.

SECTION 2. Community health grant program advisory committee - Duties of state health officer.

1. The state health officer shall establish a community health grant program advisory committee and shall appoint, after consulting with the governor, appropriate members to advise the state department of health in the development of a community health grant program. The state health officer, who shall be the chairman of the committee, shall appoint to the committee the state tobacco control administrator; one high school student; one student of a postsecondary institution in the state; one representative of a nongovernmental tobacco control organization; and one law enforcement officer. In addition to the members appointed by the state health officer, the committee must include:

a. One individual appointed by the North Dakota Indian affairs commission;

b. One individual appointed by the North Dakota public health association;

c. The superintendent of public instruction or the superintendent's designee;

d. An academic researcher with expertise in tobacco control and health promotion intervention, appointed by the dean of the university of North Dakota school of medicine and health sciences; and

e. One physician appointed by the North Dakota medical association.

2. Members of the committee who are not state employees or officers are entitled to be compensated at a rate of sixty-two dollars and fifty cents per day and are entitled to mileage and expenses as provided by law for state officers and employees. A state employee who is a member of the committee must receive that employee's regular salary and is entitled to mileage and expenses, to be paid by the employing agency.

3. The state department of health, with the committee's involvement, shall provide assistance to:

a. Evaluate programs;

b. Promote media advocacy by working with statewide media associations;

c. Implement smoke-free policies by involving antitobacco groups in promoting the need for smoke-free public buildings;

d. Work to reduce minors' access to tobacco in all communities;

e. Facilitate the coordination of program components with the local level; and

f. Involve state agencies, law enforcement, and local government in the administration and management of the program.

4. The state health officer shall monitor the implementation of the community health grant program. The state health officer shall provide reports to the legislative council regarding the implementation of the program not later than December 31, 2001, and November 1, 2002. Upon request, the state health officer shall provide assistance to any interim legislative committee that may study the implementation of the community health grant program and shall recommend any legislation that the community health grant program advisory committee considers appropriate to improve the community health grant program.

SECTION 3. APPROPRIATION. There is appropriated out of any moneys in the community health trust fund, not otherwise appropriated, the sum of $100,000, or so much of the sum as may be necessary, to the state department of health for the purpose of funding the community health grant program advisory committee, for the biennium beginning July 1, 2001, and ending June 30, 2003.

SECTION 4. APPROPRIATION. There is appropriated out of any moneys in the community health trust fund, not otherwise appropriated, the sum of $250,000, or so much of the sum as may be necessary, to the state department of health for the purpose of funding grants to cities and counties on a dollar-for-dollar matching fund basis for city and county employee tobacco education and cessation programs, for the biennium beginning July 1, 2001, and ending June 30, 2003.

SECTION 5. ALCOHOL, TOBACCO, AND DRUG ABUSE PROGRAMS - LEGISLATIVE COUNCIL STUDY. During the 2001-02 interim, the legislative council shall consider studying the programs that deal with the prevention and treatment of alcohol, tobacco, and drug abuse and other kinds of risk-associated behavior which are operated by various state agencies, including the department of corrections and rehabilitation, the attorney general, the state department of health, the department of human services, the department of public instruction, the department of transportation, the national guard, and the supreme court, and whether better coordination among the programs within those agencies may lead to a more effective and cost-efficient way of operating the programs and providing services. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the fifty-eighth legislative assembly."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

Dept. 301 - State Department of Health - House Action

The bill as amended establishes a community health grant program, allocates moneys appropriated for the program, establishes a community health grant program advisory committee, provides appropriations from the community health trust fund of $100,000 for the expenses of the committee and $250,000 for matching grants to cities and counties for city and county employee tobacco education and cessation programs, and provides for a Legislative Council study of alcohol, tobacco, and drug abuse programs. The provision to allow the community health trust fund to retain any interest earned is removed.

end

REPORT OF STANDING COMMITTEE

SB 2454: Finance and Taxation Committee (Rep. Carlson, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (12 YEAS, 2 NAYS, 1 ABSENT AND NOT VOTING). SB 2454 was placed on the Sixth order on the calendar.

In lieu of the amendments adopted by the House as printed on pages 1154 and 1155 of the House Journal, Senate Bill No. 2454 is amended as follows:

Page 1, line 5, remove "and" and after "date" insert "; and to provide an expiration date"

Page 2, line 6, replace "two and one-tenth" with "one and five-hundredths"

Page 2, line 16, replace "eight-tenths" with "nine-tenths"

Page 2, line 18, replace "is effective for taxable events occurring after" with "becomes effective on the first day of the first month after the tax commissioner certifies to the governor and the office of the legislative council that a refining facility is operational in this state which has a production capacity of at least ten million gallons [37854000 liters] of biodiesel per year.

2001 SENATE HUMAN SERVICES

CONFERENCE COMMITTEE

SB 2380

2001 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. CC SB 2380

Senate Human Services Committee

☒ Conference Committee

Hearing Date April 11, 2001

Tape Number		Side A	Side B	Meter #
	1		X	
	2	X		
April 12, 2001	1	X		
Committee Clerk Signature		Carol Zolondek		

Minutes:

The conference committee, SENATOR LEE, SENATOR FISCHER, SENATOR MATHERN, REPRESENTATIVE PRICE, REPRESENTATIVE DEVLIN, REPRESENTATIVE SANDVIG, was called to order by Chairperson LEE.

REPRESENTATIVE PRICE explained the House amendments. It was hoghoused by the House. The bill was discussed during the interim. It was important to hit every area so it would not be population controlled. The public health and the school board need to work together. They are going to come up with their idea for the grant dollars. The grant dollars have to be applied for through the Health Dept. Flexibility is available in rural area for members on the committee. We feel that the counties that have less than 10,000 population, 40 counties, need an extra boost to get started hence, the last sentence gives them $5,000 per biennium. The next section we stressed what the Blue Ribbon suggested. This is not all but just four of the ones we stressed. The others will probably have to be targeted next session. We think we have covered as far as

expertise. The reimbursement is listed next. The Dept. Of Health with the committee, it says what they are supposed to do with the evaluating that will even go beyond that. There is going to have to be criteria in there that will work for Fargo or Slope County. We want flexibility to come out as much as possible. A lot of this is written with flexibility with the oversight of State Health Officer and Committee. Section 3 is the dollar amount that it estimates it will cost to run the committee. Section 4 is for a pilot project to do tobacco cessation for employees of cities and counties. The people that did both counseling and drugs or patch were successful. Section 5 is a study of how the funds are distributed and if they are doing what is expected of them.

SENATOR LEE brought amendments that would prevent a process that matching funds have to follow in their regulations. SENATOR MATHERN questioned page 2 on CDC is noted and community programs are outlined from there. I don't see specific reference of following through with media, dealing with chronic, surveillance of these programs, counter marketing. I'm concerned that why is there no elaboration from that suggestion. REPRESENTATIVE PRICE: The chronic disease is addressed at the top of the page. In the Blue Ribbon Panel book they listed four of the nine as priorities because there were not enough funds to address all nine at this time. The surveillance and monitoring is built into the application. SENATOR MATHERN referred to the concern of a state plan. SENATOR FISCHER confirmed that one plan may not fit all. REPRESENTATIVE PRICE has no opposition to a state plan, however, this is such a changing field that goals for each section will be different. Until we find out what parts of the state are starting where we need the flexibility.

Discussion ensued over these concerns. It was agreed to add on page 5, sections a. (5) Restrict minors' access to tobacco; (6) Deter smoking in public places; (7) Monitor program accountability relating to tobacco-related behaviors, attitudes, and health outcomes. Under b. (6)

Monitor program accountability relating to tobacco-related behaviors, attitudes, and health outcomes. In section 2, 3. (g) Assist the state in screening and implementing the grants. Adding section 5. Gifts, Grants, Donations. The ND Department of Health or public health units may accept any gifts, grants or donations, whether conditional or unconditional. The Department of Health or Public health units may enter into contracts with public or private entities and may extend any moneys available to it in order to obtain matching funds for the purpose of this Act. All moneys received as gifts, grants, or donations under this section are appropriated as a standing and continuing appropriation to the ND health department of public health units. MARK JOHNSON stated that the State Health Department should be included. BOB BARNETT encourages this language. No hindrance to money. Public Health or State Health Department.

The meeting was adjourned until amendments were drawn.

April 12, 2001, Tape 1, Side A

SENATOR LEE called committee to order with all members present. Amendments were reviewed. REPRESENTATIVE PRICE the House Recede from the House amendments and moved the amendments. SENATOR FISCHER seconded the motion. Discussion. Roll call vote carried 6-0.

SENATOR MATHERN proposed amendments 10732.0707. The need of a state plan. Discussion on amendments. REPRESENTATIVE PRICE stated that they had prioritized four of the nine Blue Ribbon priorities. SENATOR MATHERN: Efforts will not be lost and that includes a direction for all. It will make a stronger bill in Senate; it adds to it. REPRESENTATIVE SANDVIG: We need to know why the money is going to Dept or health units. Supports Senator Mathern's amendments. REPRESENTATIVE DEVLIN: State plan

will come out of Bismarck and one plan doesn't fit everybody. We will loose creative plans that will come from bottom up and not state down. Discussion ensued. SENATOR MATHERN moved amendments 0707 adding section 1 & 7 to amendments and first sentence in section 2. REPRESENTATIVE SANDVIG seconded the motion. Discussion on the amendments was held. Roll call vote failed 2-4-0. The amendments were not adopted. The bill will stand with the previous amendments on it. The committee was adjourned.

PROPOSED AMENDMENTS TO REENGROSSED SENATE BILL NO. 2380

That the House recede from its amendments as printed on pages 1162-1165 of the Senate Journal and pages 1267-1270 of the House Journal and that Reengrossed Senate Bill No. 2380 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a community health grant program; to provide an appropriation; to provide a continuing appropriation; and to provide for a legislative council study.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Community health grant program.

1. The state department of health shall establish a community health grant program. The primary purpose of the program is to prevent or reduce tobacco usage in the state by strengthening community-based public health programs and by providing assistance to public health units and communities throughout the state. The program must build on and may not duplicate existing programs. Grants awarded under the program must be awarded on a noncompetitive basis using the per capita formula provided for in this subsection. The program must, to the extent funding is available, follow guidelines concerning tobacco prevention programs recommended by the centers for disease control and prevention. Entities awarded grants under the program may contract with or award grants to private providers that conduct tobacco cessation programs. Not more than five percent of the community health grant program funds may be expended for surveillance and evaluation activities. Funds appropriated for the program must be allocated as follows:

   a. Forty percent of all funds appropriated for the program must be granted to a public health unit or to cooperating public health units that have an agreement with school boards concerning preventive health programs to be funded. The program must be developed with student participation and must include a plan to reduce student tobacco use.

   b. Forty percent of all funds appropriated for the program must be granted to a public health unit or to cooperating public health units that have established a unitwide plan, developed in cooperation with local elected officials in the unit's jurisdiction, concerning the preventive health programs to be funded. The plan must address programs to reduce tobacco use by the residents living in the counties serviced by the units; however, the plan may include other chronic disease programs. In addition to any grants received under this subdivision, each county with a population of less than ten thousand must receive five thousand dollars per biennium to be used to implement the county's programs.

   c. Twenty percent of all funds appropriated for the program must be granted to public health units to supplement existing state aid from other sources. Each unit must receive one percent of the amount allocated under this subsection for each county within the unit and the remaining amount must be distributed to each unit on a per capita basis.

2. The state department of health, in establishing the community health grant program, shall build upon the state's existing tobacco control grant program activities and shall follow the centers for disease control and prevention's best practices for comprehensive tobacco control programs. The department shall encourage applicants to include in their plans:

   a. Community programs that:

      (1) Engage youth in the development and implementation of interventions;

      (2) Develop partnerships with local organizations;

      (3) Conduct educational programs at local levels;

      (4) Promote government and voluntary health policies, such as clean indoor air, youth access, and treatment coverage;

      (5) Restrict minors' access to tobacco; and

      (6) Deter smoking in public places; and

      (7) Monitor program accountability relating to tobacco-related behaviors, attitudes, and health outcomes.

   b. Promotion of school programs by partnering with public health organizations, school boards, education associations, and other organizations in each county to provide school programs that promote:

      (1) Tobacco-free policies;

      (2) Evidence-based curricula;

      (3) Teacher training;

      (4) Parental involvement; and

      (5) Cessation services for students and staff; and

      ~~(6) Monitor program accountability relating to tobacco-related behaviors, attitudes, and health outcomes.~~

SECTION 2. Community health grant program advisory committee - Duties of state health officer.

1. The state health officer shall establish a community health grant program advisory committee and shall appoint, after consulting with the governor, appropriate members to advise the state department of health in the development of a community health grant program. The state health officer, who shall be the chairman of the committee, shall appoint to the committee the state tobacco control administrator; one high school student; one student of a postsecondary institution in the state; one representative of a nongovernmental tobacco control organization; and one law enforcement officer. In addition to the members appointed by the state health officer, the committee must include:

   a. One individual appointed by the North Dakota indian affairs commission;

b. One individual appointed by the North Dakota public health association;

c. The superintendent of public instruction or the superintendent's designee;

d. An academic researcher with expertise in tobacco control and health promotion intervention, appointed by the dean of the university of North Dakota school of medicine and health sciences; and

e. One physician appointed by the North Dakota medical association.

2. Members of the committee who are not state employees or officers are entitled to be compensated at a rate of sixty-two dollars and fifty cents per day and are entitled to mileage and expenses as provided by law for state officers and employees. A state employee who is a member of the committee must receive that employee's regular salary and is entitled to mileage and expenses, to be paid by the employing agency.

3. The state department of health, with the committee's involvement, shall provide assistance to:

a. Evaluate programs;

b. Promote media advocacy by working with statewide media associations;

c. Implement smoke-free policies by involving antitobacco groups in promoting the need for smoke-free public buildings;

d. Work to reduce minors' access to tobacco in all communities;

e. Facilitate the coordination of program components with the local level;

f. Involve state agencies, law enforcement, and local government in the administration and management of the program; and

g. Assist the state in screening and implementing the grants.

4. The state health officer shall monitor the implementation of the community health grant program. The state health officer shall provide reports to the legislative council regarding the implementation of the program not later than December 31, 2001, and November 1, 2002. Upon request, the state health officer shall provide assistance to any interim legislative committee that may study the implementation of the community health grant program and shall recommend any legislation that the community health grant program advisory committee considers appropriate to improve the community health grant program.

SECTION 3. Gifts, grants, and donations. The ~~North Dakota~~ department of health or public health units may accept any gifts, grants, or donations, whether conditional or unconditional. The department of health or public health units may enter into contracts with public or private entities and may expend any ~~money~~ available to it in order to obtain matching funds for the purposes of this Act. All ~~money~~ received as gifts, grants, or donations under this section are appropriated as a standing and continuing ~~appropriation~~ to the ~~North Dakota~~ health department or ~~public health units~~.

SECTION 4. APPROPRIATION. There is appropriated out of any moneys in the community health trust fund, not otherwise appropriated, the sum of $100,000, or so much of the sum as may be necessary, to the state department of health for the

purpose of funding the community health grant program advisory committee, for the biennium beginning July 1, 2001, and ending June 30, 2003.

SECTION 5. APPROPRIATION. There is appropriated out of any moneys in the community health trust fund, not otherwise appropriated, the sum of $250,000, or so much of the sum as may be necessary, to the state department of health for the purpose of funding grants to cities and counties on a dollar-for-dollar matching fund basis for city and county employee tobacco education and cessation programs, for the biennium beginning July 1, 2001, and ending June 30, 2003.

SECTION 6. ALCOHOL, TOBACCO, AND DRUG ABUSE PROGRAMS - LEGISLATIVE COUNCIL STUDY. During the 2001-02 interim, the legislative council shall consider studying the programs that deal with the prevention and treatment of alcohol, tobacco, and drug abuse and other kinds of risk-associated behavior which are operated by various state agencies, including the department of corrections and rehabilitation, the attorney general, the state department of health, the department of human services, the department of public instruction, the department of transportation, the national guard, and the supreme court, and whether better coordination among the programs within those agencies may lead to a more effective and cost-efficient way of operating the programs and providing services. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the fifty-eighth legislative assembly."

Renumber accordingly

Date: 4/12/01

Roll Call Vote #: 1

2001 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2380

Senate Human Services Committee

☐ Subcommittee on

or

☒ Conference Committee

Legislative Council Amendment Number House Recedes from House Amendment

Action Taken amendments 10732.0708 adopted.

Motion Made By Rep Price Seconded By Sen Fischer

Senators	Yes	No	Rep Senators	Yes	No
Sen Lee	✓		Rep Price	✓	
Sen Fischer	✓		Rep Devlin	✓	
Sen T Mathern	✓		Rep Sandvig	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment Sen Lee / Rep Price

If the vote is on an amendment, briefly indicate intent:

Prepared by the Legislative Council staff for
Senator T. Mathern
April 12, 2001

PROPOSED AMENDMENTS TO REENGROSSED SENATE BILL NO. 2380

That the House recede from its amendments as printed on pages 1162-1165 of the Senate Journal and pages 1267-1270 of the House Journal and that Reengrossed Senate Bill No. 2380 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a community health grant program; to provide an appropriation; to provide for a legislative council study; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. State plan for tobacco prevention and dependence treatment. Before January 15, 2002, the state health officer, based on the advice of the community health grant program advisory committee established in section 3 of this Act and on public comment, shall establish and implement a tobacco use prevention and dependence treatment plan that is a sustainable, long-term, comprehensive program that integrates science-based, comprehensive, and effective programs including counter-marketing and public education programs, community-based programs, chronic disease programs, treatment of tobacco dependence, school-based programs, enforcement programs, and statewide programs and which includes a mechanism for ongoing monitoring and evaluation of the program. The plan must include all components of the centers for disease control and prevention's best practices for comprehensive tobacco control programs.

SECTION 2. Community health grant program.

1. The state department of health shall establish a community health grant program consistent with the plan established under section 1 of this Act. The primary purpose of the program is to prevent or reduce tobacco usage in the state by strengthening community-based public health programs and by providing assistance to public health units and communities throughout the state. The program must build on and may not duplicate existing programs. Grants awarded under the program must be awarded on a noncompetitive basis using the per capita formula provided for in this subsection. The program must, to the extent funding is available, follow guidelines concerning tobacco prevention programs recommended by the centers for disease control and prevention. Entities awarded grants under the program may contract with or award grants to private providers that conduct tobacco cessation programs. Not more than five percent of the community health grant program funds may be expended for surveillance and evaluation activities. Funds appropriated for the program must be allocated as follows:

   a. Forty percent of all funds appropriated for the program must be granted to a public health unit or to cooperating public health units that have an agreement with school boards concerning preventive health programs to be funded. The program must be developed with student participation and must include a plan to reduce student tobacco use.

   b. Forty percent of all funds appropriated for the program must be granted to a public health unit or to cooperating public health units that have established a unitwide plan, developed in cooperation with local elected officials in the unit's jurisdiction, concerning the preventive

health programs to be funded. The plan must address programs to reduce tobacco use by the residents living in the counties serviced by the units; however, the plan may include other chronic disease programs. In addition to any grants received under this subdivision, each county with a population of less than ten thousand must receive five thousand dollars per biennium to be used to implement the county's programs.

c. Twenty percent of all funds appropriated for the program must be granted to public health units to supplement existing state aid from other sources. Each unit must receive one percent of the amount allocated under this subsection for each county within the unit and the remaining amount must be distributed to each unit on a per capita basis.

2. The state department of health, in establishing the community health grant program, shall build upon the state's existing tobacco control grant program activities and shall follow the centers for disease control and prevention's best practices for comprehensive tobacco control programs. The department shall encourage applicants to include in their plans:

a. Community programs that:

(1) Engage youth in the development and implementation of interventions;

(2) Develop partnerships with local organizations;

(3) Conduct educational programs at local levels; and

(4) Promote government and voluntary health policies, such as clean indoor air, youth access, and treatment coverage.

b. Promotion of school programs by partnering with public health organizations, school boards, education associations, and other organizations in each county to provide school programs that promote:

(1) Tobacco-free policies;

(2) Evidence-based curricula;

(3) Teacher training;

(4) Parental involvement; and

(5) Cessation services for students and staff.

SECTION 3. Community health grant program advisory committee - Duties of state health officer.

1. The state health officer shall establish a community health grant program advisory committee and shall appoint, after consulting with the governor, appropriate members to advise the state department of health in the development of a community health grant program. The state health officer, who shall be the chairman of the committee, shall appoint to the committee the state tobacco control administrator; one high school student; one student of a postsecondary institution in the state; one representative of a nongovernmental tobacco control organization; and one law

enforcement officer. In addition to the members appointed by the state health officer, the committee must include:

a. One individual appointed by the North Dakota Indian affairs commission;

b. One individual appointed by the North Dakota public health association;

c. The superintendent of public instruction or the superintendent's designee;

d. An academic researcher with expertise in tobacco control and health promotion intervention, appointed by the dean of the university of North Dakota school of medicine and health sciences; and

e. One physician appointed by the North Dakota medical association.

2. Members of the committee who are not state employees or officers are entitled to be compensated at a rate of sixty-two dollars and fifty cents per day and are entitled to mileage and expenses as provided by law for state officers and employees. A state employee who is a member of the committee must receive that employee's regular salary and is entitled to mileage and expenses, to be paid by the employing agency.

3. The state department of health, with the committee's involvement, shall provide assistance to:

a. Evaluate programs;

b. Promote media advocacy by working with statewide media associations;

c. Implement smoke-free policies by involving antitobacco groups in promoting the need for smoke-free public buildings;

d. Work to reduce minors' access to tobacco in all communities;

e. Facilitate the coordination of program components with the local level; and

f. Involve state agencies, law enforcement, and local government in the administration and management of the program.

4. The state health officer shall monitor the implementation of the community health grant program. The state health officer shall provide reports to the legislative council regarding the implementation of the program not later than December 31, 2001, and November 1, 2002. Upon request, the state health officer shall provide assistance to any interim legislative committee that may study the implementation of the community health grant program and shall recommend any legislation that the community health grant program advisory committee considers appropriate to improve the community health grant program.

SECTION 4. APPROPRIATION. There is appropriated out of any moneys in the community health trust fund, not otherwise appropriated, the sum of $100,000, or so much of the sum as may be necessary, to the state department of health for the purpose of funding the community health grant program advisory committee, for the biennium beginning July 1, 2001, and ending June 30, 2003.

SECTION 5. APPROPRIATION. There is appropriated out of any moneys in the community health trust fund, not otherwise appropriated, the sum of $250,000, or so much of the sum as may be necessary, to the state department of health for the purpose of funding grants to cities and counties on a dollar-for-dollar matching fund basis for city and county employee tobacco education and cessation programs, for the biennium beginning July 1, 2001, and ending June 30, 2003.

SECTION 6. ALCOHOL, TOBACCO, AND DRUG ABUSE PROGRAMS - LEGISLATIVE COUNCIL STUDY. During the 2001-02 interim, the legislative council shall consider studying the programs that deal with the prevention and treatment of alcohol, tobacco, and drug abuse and other kinds of risk-associated behavior which are operated by various state agencies, including the department of corrections and rehabilitation, the attorney general, the state department of health, the department of human services, the department of public instruction, the department of transportation, the national guard, and the supreme court, and whether better coordination among the programs within those agencies may lead to a more effective and cost-efficient way of operating the programs and providing services. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the fifty-eighth legislative assembly.

SECTION 7. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

Date: 4/12/01

Roll Call Vote #: 2

2001 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2380

Senate Human Services Committee

☐ Subcommittee on

or

☒ Conference Committee

Legislative Council Amendment Number 10732.0707

Action Taken amendment failed

Motion Made By Sen. Mathern Seconded By Rep Sanding

Senators	Yes	No	Rep. Senators	Yes	No
Sen Lee		✓	Rep Price		✓
Sen Fischer		✓	Rep Devlin		✓
Sen Mathern	✓		Rep Sanding	✓	

Total (Yes) 2 No 4

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

not adopted

REPORT OF CONFERENCE COMMITTEE

SB 2380, as reengrossed: Your conference committee (Sens. Lee, Fischer, T. Mathern and Reps. Price, Devlin, Sandvig) recommends that the **HOUSE RECEDE** from the House amendments on SJ pages 1162-1165, adopt amendments as follows, and place SB 2380 on the Seventh order:

That the House recede from its amendments as printed on pages 1162-1165 of the Senate Journal and pages 1267-1270 of the House Journal and that Reengrossed Senate Bill No. 2380 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a community health grant program; to provide an appropriation; to provide a continuing appropriation; and to provide for a legislative council study.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Community health grant program.

1. The state department of health shall establish a community health grant program. The primary purpose of the program is to prevent or reduce tobacco usage in the state by strengthening community-based public health programs and by providing assistance to public health units and communities throughout the state. The program must build on and may not duplicate existing programs. Grants awarded under the program must be awarded on a noncompetitive basis using the per capita formula provided for in this subsection. The program must, to the extent funding is available, follow guidelines concerning tobacco prevention programs recommended by the centers for disease control and prevention. Entities awarded grants under the program may contract with or award grants to private providers that conduct tobacco cessation programs. Not more than five percent of the community health grant program funds may be expended for surveillance and evaluation activities. Funds appropriated for the program must be allocated as follows:

   a. Forty percent of all funds appropriated for the program must be granted to a public health unit or to cooperating public health units that have an agreement with school boards concerning preventive health programs to be funded. The program must be developed with student participation and must include a plan to reduce student tobacco use.

   b. Forty percent of all funds appropriated for the program must be granted to a public health unit or to cooperating public health units that have established a unitwide plan, developed in cooperation with local elected officials in the unit's jurisdiction, concerning the preventive health programs to be funded. The plan must address programs to reduce tobacco use by the residents living in the counties serviced by the units; however, the plan may include other chronic disease programs. In addition to any grants received under this subdivision, each county with a population of less than ten thousand must receive five thousand dollars per biennium to be used to implement the county's programs.

   c. Twenty percent of all funds appropriated for the program must be granted to public health units to supplement existing state aid from other sources. Each unit must receive one percent of the amount allocated under this subsection for each county within the unit and the

remaining amount must be distributed to each unit on a per capita basis.

2. The state department of health, in establishing the community health grant program, shall build upon the state's existing tobacco control grant program activities and shall follow the centers for disease control and prevention's best practices for comprehensive tobacco control programs. The department shall encourage applicants to monitor program accountability with respect to tobacco-related behaviors, attitudes, and health outcomes and to include in their plans:

   a. Community programs that:

      (1) Engage youth in the development and implementation of interventions;

      (2) Develop partnerships with local organizations;

      (3) Conduct educational programs at local levels;

      (4) Promote government and voluntary health policies, such as clean indoor air, youth access, and treatment coverage;

      (5) Restrict minors' access to tobacco; and

      (6) Deter smoking in public places.

   b. Promotion of school programs by partnering with public health organizations, school boards, education associations, and other organizations in each county to provide school programs that promote:

      (1) Tobacco-free policies;

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1. The state health officer shall establish a community health grant program advisory committee and shall appoint, after consulting with the governor, appropriate members to advise the state department of health in the development of a community health grant program. The state health officer, who shall be the chairman of the committee, shall appoint to the committee the state tobacco control administrator; one high school student; one student of a postsecondary institution in the state; one representative of a nongovernmental tobacco control organization; and one law enforcement officer. In addition to the members appointed by the state health officer, the committee must include:

a. One individual appointed by the North Dakota Indian affairs commission;

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c. The superintendent of public instruction or the superintendent's designee;

d. An academic researcher with expertise in tobacco control and health promotion intervention, appointed by the dean of the university of North Dakota school of medicine and health sciences; and

e. One physician appointed by the North Dakota medical association.

2. Members of the committee who are not state employees or officers are entitled to be compensated at a rate of sixty-two dollars and fifty cents per day and are entitled to mileage and expenses as provided by law for state officers and employees. A state employee who is a member of the committee must receive that employee's regular salary and is entitled to mileage and expenses, to be paid by the employing agency.

3. The state department of health, with the committee's involvement, shall provide assistance to:

a. Evaluate programs;

b. Promote media advocacy by working with statewide media associations;

c. Implement smoke-free policies by involving antitobacco groups in promoting the need for smoke-free public buildings;

d. Work to reduce minors' access to tobacco in all communities;

e. Facilitate the coordination of program components with the local level;

f. Involve state agencies, law enforcement, and local government in the administration and management of the program; and

g. Assist the state in screening and implementing the grants.

4. The state health officer shall monitor the implementation of the community health grant program. The state health officer shall provide reports to the legislative council regarding the implementation of the program not later than December 31, 2001, and November 1, 2002. Upon request, the state health officer shall provide assistance to any interim legislative committee that may study the implementation of the community health grant program and shall recommend any legislation that the community health grant program advisory committee considers appropriate to improve the community health grant program.

SECTION 3. Gifts, grants, and donations - Continuing appropriation. The state department of health and public health units may accept any gifts, grants, or donations, whether conditional or unconditional. The department of health or public health units may contract public or private entities and may expend any available

moneys to obtain matching funds for the purposes of this Act. All moneys received by the state department of health as gifts, grants, or donations under this section are appropriated on a continuing basis to the state department of health.

SECTION 4. APPROPRIATION. There is appropriated out of any moneys in the community health trust fund, not otherwise appropriated, the sum of $100,000, or so much of the sum as may be necessary, to the state department of health for the purpose of funding the community health grant program advisory committee, for the biennium beginning July 1, 2001, and ending June 30, 2003.

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Renumber accordingly

Reengrossed SB 2380 was placed on the Seventh order of business on the calendar.

REPORT OF CONFERENCE COMMITTEE

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Renumber accordingly

Reengrossed SB 2380 was placed on the Seventh order of business on the calendar.

2001 TESTIMONY

SB 2380

Testimony on SB 2380
Regarding A Youth Smoking Prevention Commission
Before the
Senate Human Services Committee

Sandra Adams, Director
Division of Health Promotion
North Dakota Department of Health Promotion

January 31, 2001

Madame chairman, and members of the Committee. I am Sandra Adams, Director of the Division of Health Promotion, North Dakota Department of Health.

The Department does not support or oppose Senate Bill 2380 as written, but offers the following comments.

The Department's goal is to work towards establishing a comprehensive, statewide tobacco control program as summarized on the attached fact sheet. The Department will receive approximately $2.4 million in federal funds for tobacco control this next biennium. We propose using the $5 million in the community health trust fund to supplement this existing program, combining resources to equal approximately $7.4 million per biennium. The U.S. Centers for Disease Control and Prevention recommends that North Dakota invest $16 million per biennium into tobacco control to establish a comprehensive program. A combined budget of $7.4 million helps the state move toward a comprehensive, statewide tobacco control program.

As written, however, Senate Bill 2380:

1. Focuses solely on youth smoking prevention, which moves the state further away from a comprehensive statewide tobacco control program. This single focus also prevents the Department from using tobacco settlement dollars to supplement its current federally funded tobacco control program, which is required to have a broad focus.
2. Establishes a separate commission that is charged with developing yet another statewide tobacco control plan, when a statewide plan already exists.
3. Delays the flow of funding to communities by at least one year, as valuable time is taken to establish a new commission and develop a duplicate state plan.

Therefore, we recommend the committee consider adding language to Senate Bill 2380 that will help the Department:

1. Work toward establishing a comprehensive, statewide tobacco control program by supplementing the current federally funded tobacco control program with tobacco settlement funds.
2. Establish an advisory committee that can assure a comprehensive approach, rather than an approach focused solely on youth.
3. Allow for immediate distribution of funds for local and statewide programs.

I am happy to respond to any questions you may have. Thank you.

Page 4, remove lines 21-27. The tobacco control program conducts ongoing assessments. In the alternative, amend subsection 3 to require a biennial statewide assessment in each even-numbered year, which coincides with the youth behavioral risk factor survey. ***(Also remove "respondent identities and respondent-identifiable data" -- "protected [individually identifiable] health information" is already protected as confidential under other laws.)***

Page 4, remove lines 28-29. The 5 percent limit on administrative expenses for the advisory committee is unclear -- the bill now combines money from the CDC grant with money from the master settlement, and it is unclear if the salaries and benefits of the 4.5 Department of Health employees are to be included in the "5 percent" or if it applies only to the travel and lodging expenses of the non-government members of the advisory committee.

Page 5, lines 1-18, (relating to the criteria for awarding grants). Either delete -- and give discretion to the health officer and the committee, or revise as follows: "The committee shall meet to review applications for grants for tobacco prevention programs. To the extent reasonable and consistent with the criteria for qualified applicants set forth in the state plan, and giving due consideration to the recommendations of the committee, the state health officer shall make awards to qualified tobacco prevention programs."

Page 5, remove lines 19 and 20.

Page 5, lines 21-25, grant award announcements date. Remove or revise schedule.

Page 6, remove lines 5-7. The Attorney General already has authority to initiate action against a person who fails to carry out the requirements of a grant.

Page 6, lines 8-15. Either remove subsection 3, or remove the audit requirement in that subsection. Nonprofit agencies that receive grants are required to be audited, or must submit audited financial reports to the Internal Revenue Service.

Page 6, remove lines 16-30 (the first portion of section 9 of the bill), which amends section 54-27-25 relating to deposit of tobacco settlement funds in the community health trust fund. This section appears to be unnecessary and will reduce the flexibility of the tobacco prevention advisory committee. If there are appropriated $7 million for the tobacco prevention and control program, and under section 9 there is a required allocation of $6 million for specific programs (local public health, a healthy schools grant program, a healthy community grant program, and a statewide tobacco counter-marketing media program), there will be only a small amount of funds remaining for distribution by the advisory committee. ***Alternatively, if it is the committee's intent to add $1 million dollars to provide additional state aid to local public health units, then only subparagraph a (Page 6, lines 26-27) should be retained.***

Page 7, remove lines 1-15. This is a continuation of section 9 and is unnecessary. Specifically, pages 7, lines 10-15, are unnecessary. The Department of Health has the ability to allocate funds to meet emergencies, seek additional funds or expenditure authority from the emergency commission, or, in the case of a major disaster, seek federal aid. Also the limitation on lobbying is included in federal grants and other North Dakota laws, and is, therefore, unnecessary.

SB 2380

Testimony on SB 2380
Tobacco Prevention Advisory Committee
Before the
Senate Appropriations Committee

Darleen Bartz, Chief, Preventive Health Section
North Dakota Department of Health
February 16, 2001

Chairman Nething and members of the Committee, I am Darleen Bartz, Chief, Preventive Health Section, North Dakota Department of Health. I am here today to provide testimony on Senate Bill 2380.

The Department's goal is to work towards establishing a comprehensive, statewide tobacco control program based on the Centers for Disease Control and Prevention's (CDC) Best Practices for Comprehensive Tobacco Control Programs. The Department will receive approximately $2.4 million in federal funds for tobacco control from the CDC this upcoming biennium. We propose using the $5 million in the community health trust fund to supplement this existing program, combining resources to equal approximately $7.4 million per biennium. This proposal is consistent with the department's budget that was approved by the Governor's office. The U.S. Centers for Disease Control recommends that North Dakota invest a minimum of $16 million per biennium into tobacco control to establish a comprehensive program. A combined budget of $7.4 million helps North Dakota move toward a comprehensive, statewide tobacco control program.

As written, however, Senate Bill 2380:

1. Section 10 identifies approximately $7.5 million to be granted to a variety of entities for numerous reasons. Only $1 million is designated to be used solely for tobacco projects.
2. In section 11, we assume the federal CDC tobacco control grant to North Dakota of $2.4 million is combined with $5.2 million from the Community Health Trust Fund to total $7.6 million. Based on the information in section 10, it appears that the tobacco control funding received from CDC may be redirected by state law to be used for purposes not consistent with the CDC grant guidelines. This may place the CDC Tobacco Control grant to the Health Department in jeopardy.
3. Brings North Dakota no closer to establishing a statewide tobacco control program as endorsed by the Governor's Office.

Therefore, we recommend the committee consider revising the language in Senate Bill 2380:

1. Support establishing a comprehensive, statewide tobacco control program based on CDC's Best Practices for Tobacco Control Programs by supplementing the current federally funded tobacco control program with $5 million from the Community Health Trust Fund.
2. At a minimum, we ask that consideration be given to ensure that the anticipated CDC tobacco control grant be used for the purposes intended and not be jeopardized.
3. Examine and modify the role of the advisory committee for the tobacco control program.
4. Allow for immediate distribution of funds for local and statewide programs.

I am happy to respond to any questions you may have. Thank you.

Dept of Health

PROPOSED AMENDMENTS TO SENATE BILL NO. 2399

Page 1, delete lines 22-23.

Page 2, delete lines 1-15, replace with, "the state department of health shall use funds from the community health trust fund for implementation of a statewide tobacco control program. These funds will be used to supplement the Centers of Disease Control and Prevention grant funds received by the state for the implementation of a statewide tobacco control program based on the Centers of Disease Control's "Best Practices for Comprehensive Tobacco Control Programs.'"

Page 3, line 6, replace "7,000,000," with "$5,000,000, to be combined with $2,400,000 in federal funds, for a total of $7,400,000,"

Renumber accordingly.

The Department has prepared amendments for your consideration related to SB 2380. These amendments are:

- Place the Advisory Committee in the Department of Health, working with the State Health Officer.
- Delete the language related to the State Health Officer's Powers as they are already addressed in NDCC 23-01.
- Define the role of the Advisory Committee to provide recommendations to the State Health Officer.
- Emphasize that the plan will build upon the existing tobacco control program.
- Revise the language related to the plan to allow the Advisory Committee to have the flexibility to develop a plan based on needs identified by the committee by removing or revising the reference to section 54-27-25 of the North Dakota Century Code.
- Other amendments streamline the language in the bill and conform to other existing language in the NDCC.

Thank you for this opportunity to provide testimony. I would be happy to respond to any questions you may have. Thank you.

Submitted by State Department of Health
March 5, 2001 [Rev. 3]

PROPOSED AMENDMENTS TO SECOND ENGROSSMENT REENGROSSED
SENATE BILL NO. 2380

Page 1, remove lines 11-13. This removes the definition of the "master settlement agreement," which may be unnecessary in light of other amendments to SB 2380 – the settlement agreement is no longer referred to elsewhere in the bill.

Page 1, lines 19-20 remove "office of the governor" and insert "state department of health," which will place the tobacco prevention advisory committee within the Department of Health (which will "staff the committee – provide administrative support).

Page 2, lines 13-15, after "designee" remove the remainder of paragraph "*f*", which is unnecessary. (The state health officer is already given discretion, on the appointment.)

Page 2, remove line 24. The convening authority (the governor or state health officer) should have discretion to set the advisory committee's meeting dates. It is unnecessary to include this requirement in the law. Alternatively, on Page 2, line 24 remove "governor" and insert "state health officer" -- conforming amendment

Page 2, remove line 28-30, which removes section 3 (management of the affairs of the committee). If the committee is "advisory" to the Department of Health, there is existing authority.

Page 3, remove lines 1 and 2, the remainder of section 3.

Page 3, remove lines 3-18, which removes section 4. This section is unnecessary as the state health officer already has the powers described in section 4.

Page 3, remove lines 19-31 (removes subsection 1 of section 5). The convening authority (the governor or Health officer), and the advisory committee itself, should have discretion to set deadlines for the adoption and publication of the final state plan.

Page 4, line 8, after the period insert "2." This change emphasizes (as a separate subsection) that the comprehensive state plan must build on and not duplicate current programs.

Page 4, at the beginning of line 9 insert "3."

Testimony on SB 2380
Tobacco Prevention Advisory Committee
Before the
House Human Services Committee

Darleen Bartz, Chief, Preventive Health Section
North Dakota Department of Health
March 6, 2001

Chairman Price and members of the Committee, I am Darleen Bartz, Section Chief of the Preventive Health Section, North Dakota Department of Health. I am here today to provide testimony on Senate Bill 2380. The Department supports Senate Bill 2380 with the following comments.

The Department's goal is to work towards establishing a comprehensive, statewide tobacco control program based on the Centers for Disease Control and Prevention's (CDC) Best Practices for a Comprehensive Tobacco Control Program. The Department will receive approximately $2.4 million in federal funds for tobacco control from the CDC this next biennium. We propose using the funding in the community health trust fund to supplement this existing tobacco control program, combining resources to equal approximately $7 million per biennium. This is consistent with the Department's budget that was approved by the Governor's Office. The U.S. Centers for Disease Control and Prevention recommends that North Dakota invest $16 million per biennium into tobacco control to establish a comprehensive program. A combined budget of $7 million will help the state move toward a comprehensive, statewide tobacco control program.

The Department supports the addition of the Advisory Committee addressed in this bill related to the implementation of a comprehensive, statewide tobacco control program in North Dakota. The Department also believes it is essential to emphasize the importance to focus on youth tobacco issues in our state as a part of the program.

The interim committee spent much time studying how best to use the Community Trust Fund in North Dakota. The results of this committee recommended that $2 million be allocated to healthy schools, $2 million be allocated to healthy communities, and $1 million be allocated to healthy families. The Department believes these recommendations can be met through using these funds to work towards implementation of a comprehensive, statewide tobacco control program based on the Centers for Disease Control and Prevention's Best Practices for a Comprehensive Tobacco Control Program. This program places a strong emphasis on Tobacco Control Programs in Schools and Communities, as well as provides flexibility for communities to target the specific tobacco control issues and related chronic diseases of concern to their communities. This program also contains statewide components as well as evaluation components to reach both the urban and rural areas of our state and evaluate the progress that is made.

TESTIMONY ON SB 2380
SENATE HUMAN SERVICES COMMITTEE
January 31, 2001
By Linda Johnson, Director of School Health Programs
328-4138
Department of Public Instruction

Madam Chairman and members of the committee:

My name is Linda Johnson and I am the Director of School Health Programs for the Department of Public Instruction. I am here to provide information regarding school tobacco prevention programs in North Dakota.

Currently schools receive $9.50 per student from Safe and Drug Free Schools and Communities (SDFSC), part of the Improving America's Schools Act. These dollars are used for a variety of district-planned purposes in accordance with the authorized activities provided in this act. In addition, since 1998 SDFSC has implemented the Principles of Effectiveness into this planning process. You will find this on the attached blue sheet.

The Department collects data on the efforts of the districts. You will find this on the attached yellow sheet. We provide training in research-based curriculum that has proven effective results. The State Health Department supplements these trainings with materials. Many schools are in the process of moving toward implementation of *Life Skills Training* or *Project Toward No Tobacco Use*. You will find these brochures attached.

Realizing it takes a minimum of five years to effect a behavior change, it is imperative to encourage districts to continue in the efforts they have begun. Therefore, we recommend the committee consider adding language to Senate Bill 2380 to include the Department of Public Instruction on line 19 and 20 of page three as a reviewer of the proposed state plan.

I am happy to answer any of your questions and am available to further explain the current efforts of tobacco and youth risks prevention education in North Dakota schools.

TESTIMONY ON SB 2390
HOUSE HUMAN SERVICES COMMITTEE
March 6, 2001
by Linda L. Johnson, Director of School Health Programs
328-4138
Department of Public Instruction

Madam Chairman and members of the committee:

My name is Linda Johnson and I am the Director of School Health Programs for the Department of Public Instruction. I am here to provide information regarding school tobacco use prevention programs in North Dakota.

The Centers for Disease Control Guidelines for School Programs to Prevent Tobacco Use, which is attached, makes seven recommendations for effective school programs to prevent tobacco use. Since 1998 schools receiving Safe and Drug Free Schools funds have been learning about and implementing several of these steps including policy, research-based curriculum, teacher training, and parent and community involvement. However, the $9.50 per student is not sufficient for schools to fully implement the program and make a difference in our youth smoking numbers. In addition, these dollars are a part of the Improving America's Schools Act currently being considered for reauthorization. We are unsure what future format this program will take and the dollars allocated.

It is imperative that schools have dollars to implement a comprehensive program. The current engrossment allows schools to apply for grant money for only smoking cessation programs (Page 6, lines 29-30). The Department of Public Instruction proposes adding language to allow schools to apply for "school-based tobacco use prevention education programs as defined by the CDC Guidelines for School Programs to Prevent Tobacco Use." This broader language would include school tobacco cessation programs and allow schools to implement the other six prevention phases according to their current needs.

The attached pamphlets on *TNT Toward No Tobacco Use* and *Life Skills Training* and *Know Your Body* are the research-based programs DPI and the State Health Department collaborate in offering teacher trainings and schools are beginning to use. The Department collects data on the efforts of the districts. You will find this report attached. Notice, although schools are beginning to get these programs in place, we have a ways to go.

Let's band together to form a system of education to prevent tobacco use and bring those North Dakota smoking numbers down. A comprehensive program modeled from the CDC plan at the school and community level will make a difference.

Feel free to come to me for any information about schools and prevention programs. Thank you. Are there any questions?

Cost

The KYB program is sold in kits by grade level. Each kit costs $249. Schools may use their Safe & Drug Free Schools & Communities dollars to cover costs associated with implementing the program.

Where to Get More Information

For curriculum information contact:
American Health Foundation
B.J. Carter
(212) 551-2541

For ordering information contact:
Kendall-Hunt Publishing Co.
Marilyn Pierce
1-800-247-3458
Email: mpierce@kendallhunt.com

For technical assistance and training information contact:
ND Dept of Public Instruction
School Health Unit
Drinda Olsen
(701) 328-2269
Email: dolsen@mail.dpi.state.nd.us

Trainer Contact Info

The following training teams may be contacted directly or through DPI. Costs include training fee & expenses.

Tammie Vernon Hazen (h) 701/748-5636 (w) 701/748-6120	**Mary Bray** Hazen (h) (w) 701/748-6120
Pam Peterson Carpio (h) 701/468-5573 (w) 701/727-3310	**Shannon Spitzer** Minot (h) 701/839-5389 (w) 701/839-7135
Nancy Tisor Fargo (h) 701/235-5295 (w) 701/241-4765	**Becky Ust** Valley City (h) 701/845-5492 (w) 701/646-6202
Elonda Davidson Stanley (h) 701/628-2091 (w) 701/628-2422	

North Dakota Department of Public Instruction
Dr. Wayne G. Sanstead, State Superintendent
600 E Boulevard Ave. Dept. 201
Bismarck, North Dakota 58505-0440

Support for KYB provided by:
CDC Agreement No. U87/CCU808975-08 and
SDFSC CFDA No. 84.186A
Website: http://www.dpi.state.nd.us

Know Your Body



KYB

A comprehensive, skills-based health education program for grades K-6.

"Nobody takes better care of you than you"

A Research-Based Program

Target Audience

- Elementary school children grades K through 6.

Goals

KYB is an innovative, comprehensive, skills-based health education curriculum for children.

Developed by the American Health Foundation, KYB aims to provide young people with the knowledge, attitudes, skills, and experience necessary to practice healthy behaviors - now and in the future.

Know Your Body

Topics

Each grade level covers the following content areas:

- Core Life Skills
- Nutrition
- Exercise and Fitness
- Disease Prevention
- Drug and Alcohol Use Prevention
- Tobacco Prevention
- Growth and Development
- Social and Emotional Health
- Dental Health
- Consumer Health
- Environmental Health
- Safety
- Conflict Resolution/Violence Prevention
- HIV/AIDS

Implementation

Within each of the content areas there are a varying number of 30-50 minute lessons. Core lessons address essential information that should be considered a priority if time does not allow for the completion of all lessons.

The KYB Curriculum addresses all of the health education content areas recommended by Centers for Disease Control. Through its cross-curricula matrix, KYB can easily be integrated into the following programs in typical schools:

Lessons are adaptable to the ND Health Standards.

- Science
- Social Studies
- Math
- Language Arts
- Physical Education

Components

The KYB Program has three core components and two reinforcing components.

Core
- School Health Education Curriculum
- Teacher Training
- Assessments

Reinforcing (optional)
- Biomedical Screening
- Extracurricular Activities

Training

A one-hour awareness presentation is available for any group interested in learning more about the program.

A six-hour teacher training is available for those schools implementing the program.

A fifteen-hour teacher training is also available and may be taken for one hour of continuing education graduate credit.

Cost

Curriculum	$45
Package of 5 student workbooks	$19
Videos:	
Stand Up for Yourself! Peer Pressure and Drugs	$80
Tobacco Use Social Images	$40

Schools may use their Safe & Drug Free Schools & Community dollars to cover costs associated with implementing the program.

Where to Get More Info

For curriculum and ordering information contact:

ETR Associates
1-800-325-3048
Website: http://www.etr.org

For technical assistance and training information contact:
ND Department of Public Instruction
School Health Unit
Drinda Olsen
(701) 328-2269
Email: dolsen@mail.dpi.state.nd.us

Trainer Contact Info

The following training teams may be contacted directly or through DPI. Costs include training fee & expenses.

Jane Rodacker	Pauline Wahl
Grand Forks	Minot
(h) 701/746-9438	(h) 701/838-6022
(w) 701/746-2360	(w) 701/857-4477

North Dakota Department of Public Instruction
Dr. Wayne G. Sanstead, State Superintendent
600 E Boulevard Ave. Dept. 201
Bismarck, North Dakota 58505-0440

Support for TNT provided by:
SDFSC CFDA No. 84.186A
http://www.dpi.state.nd.us

A Tobacco Use Prevention Program for the Middle Grades



Project

TNT

Project Towards No Tobacco Use

A Research-Based Program

Target Audience

Ideally, students in 7th grade. Project TNT has been successfully implemented with students grades 5-8.

Objectives

At the completion of this program, students will have the knowledge and skills to:

- Reduce their initiation or regular use of tobacco products
- State accurate information about the course of tobacco addiction and disease, the consequences of using tobacco, and the prevalence of tobacco use among peers
- Demonstrate skills including active listening, assertive refusal, effective communication, self-esteem building, and tobacco use-specific cognitive coping skills
- Illustrate ways the media portray "social images" that influence tobacco use
- Understand and practice advocating for no tobacco use
- Make a public commitment about future intentions toward tobacco use

Topics

- Active listening skills
- Information about the course of tobacco addiction and tobacco use prevalence
- Self-esteem building
- Tobacco use-specific cognitive coping skills
- Effective communication skills
- General assertiveness, and assertive refusal learning and practice
- Counteracting media-related tobacco use social influences
- Social advocacy and public commitment about tobacco product nonuse

Implementation

Project TNT consists of ten core lessons and two booster sessions, 40-50 minutes each. The ten core lessons are designed to occur over a two-week period. The two-lesson booster was developed to be taught one year after the core lessons in a two-day sequence. Lessons are adaptable to the ND Health Standards.

Components

The Project TNT Program has two components.

- Curriculum, including a teacher's manual, student workbooks, and two videos
- Teacher training

Training

A one-hour awareness presentation is available for any group interested in learning more about the program.

A six-hour teacher training is available for those schools implementing the program.

A fifteen-hour teacher training is also available and may be taken for one hour of continuing education graduate credit.

Cost

Year 1 curriculum	$275
Pkg. of 10 student guides	$60
Year 2 curriculum	$225
Pkg. of 10 student guides	$50
Year 3 curriculum	$175
Pkg. of 10 student guides	$40
Relaxation tape	$10

Schools may use their Safe and Drug Free Schools and Communities funds to cover the costs associated with implementing this program.

Where to Get More Info

For curriculum and ordering information contact:

Princeton Health Press
(609) 921-0540

For technical assistance and training information contact:
ND Dept. of Public Instruction
School Health Unit
Drinda Olsen
(701) 328-2269
Email: dolsen@mail.dpi.state.nd.us

Trainer Contact Info

The following training teams may be contacted directly or through DPI. Costs include training fee & expenses.

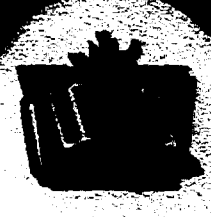
Rick Grinsteiner	Mary Eldredge-Sandbo
Devils Lake	Des Lacs
(h) 701/662-3957	(h) 701/725-4398
(w) 701/662-7664	(w) 701/725-4334

North Dakota Department of Public Instruction
Dr. Wayne G. Sanstead, State Superintendent
600 E Boulevard Ave. Dept. 201
Bismarck, North Dakota 58505-0440

Support for LST provided by:
SDFSC CFDA No. 84.186A
http://www.dpi.state.nd.us

A Research-Based Program

Life Skills Training



A Proven Approach to Drug Abuse Prevention for the Middle Grades

Target Audience

Students in grades 6 through 9. Ideally the program should begin in the 6th or 7th grade with booster sessions in subsequent grades.



Objectives

At the completion of this program, students will have the knowledge and skills to:

- Say "no" to tobacco, alcohol, and other drugs
- Develop a positive self-image
- Make decisions on their own without being influenced by peer group pressure
- Resist peer and media pressure to smoke, drink, or use other drugs
- Manage anxiety
- Build healthy relationships
- Cope with the challenges of adolescent life

Topics

- Resistance Skills, Knowledge, and Attitudes
  - Social influences to smoke, drink, or use drugs
  - Norms supporting the non-use of smoked tobacco, alcohol, and other drugs
  - Prevention-related knowledge
- Self-Management Skills
  - Problem solving and decision making
  - Personal behavior change skills (Goal-setting, self-monitoring, self-reinforcement)
  - Stress and anxiety management
- General Social Skills
  - Effective communication skills
  - Greetings and brief social exchanges
  - Meeting new people
  - Conversational skills
  - Complimenting skills
  - Assertiveness skills



Implementation

Fifteen class periods scheduled one or more times per week. Booster sessions of ten class periods in Year 2 and five class periods in Year 3. Lessons are adaptable to the ND Health Standards.

Components

The Life Skills Training Program has two components. They are:

- Curriculum, including a teacher's manual and student guides
- Teacher training

Training

A one-hour awareness presentation is available for any group interested in learning more about the program.

A six-hour teacher training is available for those schools implementing the program.

A fifteen-hour teacher training is also available and may be taken for one hour of continuing education graduate credit.

Department of Public Instruction
600 E Boulevard Ave., Dept. 201, Bismarck, ND 58505-0440
(701) 328-2260 Fax - (701) 328-2461
http://www.dpi.state.nd.us

Dr. Wayne G. Sanstead
State Superintendent

To: Chairperson Price and Members of the House Human Services Committee

From: Linda L. Johnson, Director of School Health Programs

Date: March 7, 2001

Re: SB 2380 and Youth Involvement

I continue to hear concern for youth involvement on the Tobacco Prevention Advisory Committee. This is a very legitimate concern as we need youth input, however I see some inherent problems with having a few youth on the committee. It really is putting them on the spot to speak for all their peers, a very diverse group. They may feel pressure to go with an underlying current of the decision in the room. Also, if what they say disagrees with what we know from the research to be "best practices", would the committee go with the teen advice or what research states is true for the majority of teens?

I would like to share with you a method I used in solving a very similar dilemma, and gathering youth input. Perhaps at least part of this thought process will be helpful to you in your decision making as the situations were similar. This was the situation and how we resolved it.

We were developing a curriculum and needed a video that would speak to Native American youth. We did not want to intimidate youth by having them on a panel with adults. We also wanted a cross section of youth, some with high-risk behaviors to tell us what would influence them. We decided to do a series of focus groups around the state. It was important to select moderators who were professionally trained in focus group delivery. We also very carefully crafted the questions so we would get the specifics we needed to develop the video. Each of the focus group reports was compiled into one succinct report. We were then able to use the ideas to format our video. We found the information from the focus groups very useful. After just three groups had met, we found the same issues coming out again and again. Reaching consensus was fairly easy. I will include the questions we formulated so you can have a feel for the process.

To apply the focus group model for youth input to the Tobacco Prevention Advisory Committee, a consultant with expertise in focus groups would need to be hired to manage the process. The Committee would need to react to the questions the consultant formulated to attain the answers to the issues the Committee wishes to address. A series of focus groups would be held around the state with a variety of youth and a consensus report delivered to the Committee. It may very well conclude that varying groups have a variety of needs. The Committee would then have that information to plan their youth program with youth input.

Feel free to contact me for more information at 328-4138 or ljohnson@mail.dpi.state.nd.us. Your decisions are weighty. This piece of information may help solve one of the dilemmas you are facing. I respect the many decisions you have to make in the next few days.

Enclosure

Sample of Focus Group questions to determine content of a video to be produced for Native American students to accompany a curriculum for HIV/AIDS education.

Warm up questions:
Can you tell us what television show do you watch when you get a chance and what it is about the show that makes you choose it over others?

Question 1:
Have you ever seen a television program or video that was made especially for Native American youth? Please describe what it was about. What did you like about it? What didn't you like about it?
We learned from this question, no youth had seen a video other than Dances With Wolves with Native American youth!

Question 2:
A. What comes to mind when you hear the word AIDS? B. What do you hear teenagers saying about AIDS?

Question 3:
A. What are some of the main concerns that teenagers have about AIDS? B. Do they teach about AIDS in school? C. What have you learned about how kids can be infected with the AIDS virus?

Question 4:
A. Where do kids get together in your community? B. What do kids in your community do that can put them at risk?

Question 5:
From our discussion so far, what are the important messages that need to be covered in this video?

Question 6:
The new video must use realistic language that kids can understand. Give us some examples.

Question 7:
Who should be used to get these messages across?

Question 8:
Who are the adults in your community that you would go to if you had questions about sexuality?

Question 9:
What can the elders do to help kids be proud of themselves?

Question 10:
What can the elders do to help kids be more responsible for their own actions?

Questions 11:
If you could select only one of the messages that we discussed here today to be included in the new video, which do you think would be the <u>most important</u>?

Question 12:
Are there any issues that you feel may have been overlooked? Have we missed anything?



1999 North Dakota
Youth Risk Behaviors

Healthy kids make better students.
Better students make healthy communities.

–Association for State and Territorial Health Officials
–Council of Chief State School Officers

Tobacco

Alcohol and Drug Use **Drinking and Driving**

Dietary Behaviors **Physical Activity** **Body Image**

Suicide **Violence** **Seat Belts**

STDs **Sexual Behavior** **HIV/AIDS**

The Youth Risk Behavior Survey (YRBS) monitors six categories of priority health-risk behaviors among youth and young adults. Data were obtained on behaviors that contribute to injuries, tobacco use, alcohol and other drug use, sexual behaviors, dietary behaviors and physical activity.

During the spring of 1999, the North Dakota Department of Health and the North Dakota Department of Public Instruction conducted the fourth biennial YRBS. Weighted data were obtained from 1,666 seventh and eighth grade students and 1,823 students in grades nine through 12. These results can be used to make important inferences about all students in grades seven through 12 because of the random, research-based mode of selection.

The 1999 data are compared to the1999 National[1] and 1995 state weighted survey results to indicate trends. Other sources of information are footnoted.

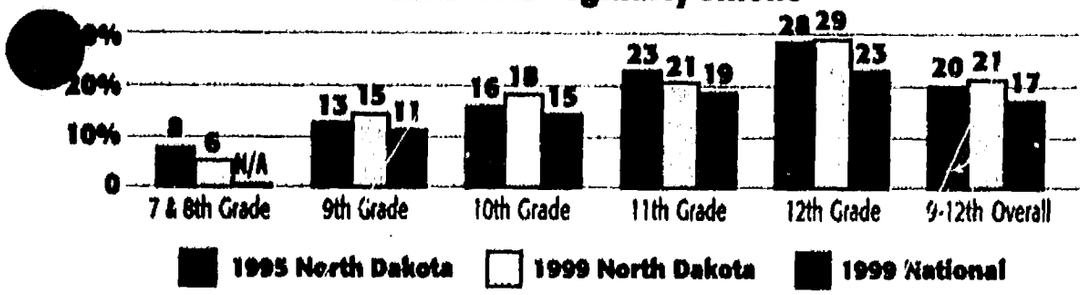
North Dakota Department of Health
Murray G. Sagsveen
State Health Officer
600 E. Boulevard Ave., Dept. 301
Bismarck, N.D. 58505-0200

North Dakota Department of Public Instruction
Dr. Wayne G. Sanstead
State Superintendent
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Support provided by:
Centers for Disease Control & Prevention
Cooperative Agreement No.
U87CCU808975-08
PHHS Block Grant
No. 99-B1-ND-PRVS

Cigarette Smoking

Teens who regularly smoke



If current patterns continue, one in three adolescents who are regular smokers eventually will die of a smoking-related disease.[2]

Of the children who smoke three to four cigarettes per day, 75 percent become habitual smokers. Use of tobacco also greatly increases the likelihood of other drug use. This has led nicotine to be called the "gateway" drug.[3]

Percentage of students younger than age 18 who were current cigarette smokers and reported having purchased cigarettes without being asked to show proof of age:

	'95	'99
ND 9-12 Grade	64%	66%
National	--	70%

Regular Smoker:
A person who smoked on 20 or more of the past 30 days.

Current Smoker:
A person who has smoked within the last 30 days.

Fifty-four percent of regular smokers in North Dakota high schools have tried marijuana.

Chewing Tobacco

Used chewing tobacco and/or snuff during the past 30 days:

ND 7 & 8 Grade	'95	'99
Males	--	10%
Females	--	5%

ND 9-12 Grade	'95	'99
Males	24%	25%
Females	3%	5%

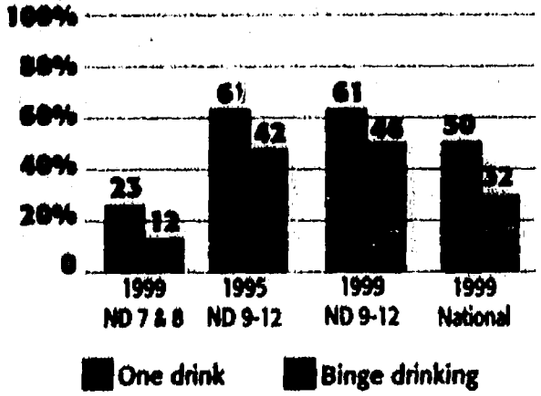
National 9-12 Grade	'99
Males	14%
Females	1%

Tobacco
Alcohol and Drug Use
Drinking and Driving
Dietary Behaviors
Physical Activity
Body Image
Suicide
Violence
Seat Belts
STDs
Sexual Behavior
HIV/AIDS

Alcohol Use

In 1999, 54 percent of North Dakota seventh and eighth grade students and 18 percent of ninth through 12th grade students reported they had never consumed alcohol.

Alcohol use during 30 days prior to the survey



Binge Drinking: Drinking five or more drinks of alcohol in a row within a couple of hours.

Drinking and Driving

Percentage of students who rode with a driver who had been drinking alcohol or who drove after drinking alcohol during the 30 days prior to the survey:

	Rode with a driver who had been drinking		Drove after drinking	
	'95	'99	'95	'99
9th Grade	41%	36%	19%	15%
10th Grade	43%	48%	28%	29%
11th Grade	60%	52%	42%	38%
12th Grade	52%	56%	43%	45%
ND Sample 9-12	49%	48%	33%	31%
National 9-12	39%	33%	15%	13%

In 1999, the percentage of North Dakota students grades nine through 12 who reported drinking and driving was higher than in any other state.

In North Dakota, 63 percent of high school binge drinkers admitted to driving a car or vehicle when they had been drinking in the 30 days before the survey.

In 1999, there were 119 North Dakota highway fatalities; in 50 percent alcohol or drugs were involved.[5]

Drug Use

Students reported using the following substances at some time in their lives

	North Dakota 7 & 8		North Dakota 9 - 12		National
	1995	1999	1995	1999	1999
Injectable drugs	–	–	4%	3%	2%
Steroids	4%	4%	5%	3%	4%
Cocaine	3%	4%	5%	8%	10%
Inhalants	19%	16%	20%	16%	15%
Marijuana	11%	12%	26%	36%	47%
Metamphetamines	–	6%	–	11%	9%

In 1999, 24 percent of North Dakota students grades nine through 12 had been offered, sold or given illegal drugs on school property during the preceding 12 months.

Reasons for referral to juvenile court services in North Dakota [4]

	1997	1998	% Increase
DUI Violations	89	105	18%
Controlled Substance	435	517	19%
Possession/Purchase of Alcokol	2,378	2,781	17%

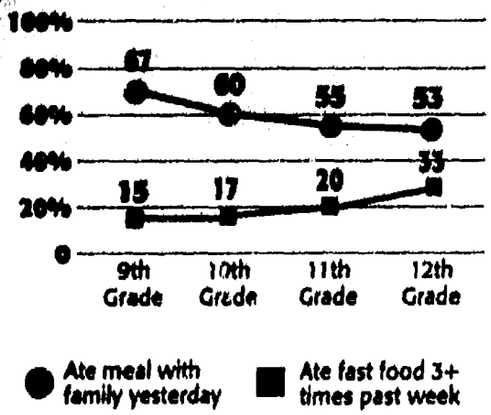
Alcohol and Drug Use **Drinking and Driving**

Dietary Behaviors **Physical Activity** **Body Image**

Suicide **Violence** **Seat Belts**

Dietary Behaviors

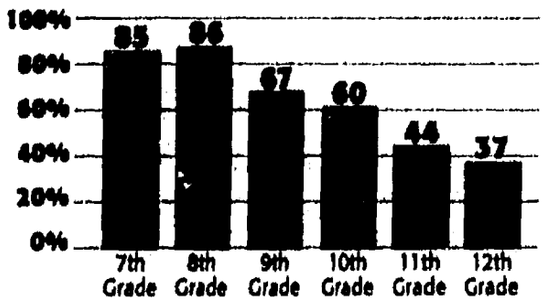
Eating with family and eating fast food



Physical Activity

Physical education class participation dropped significantly between grades seven and 12, from 85 percent of seventh graders to 37 percent of 12th graders attending one or more times per week.

Students attending physical education class at least once a week



Seventh & Eighth Grade: 77 percent were involved in a team sport run by the school or other organization.

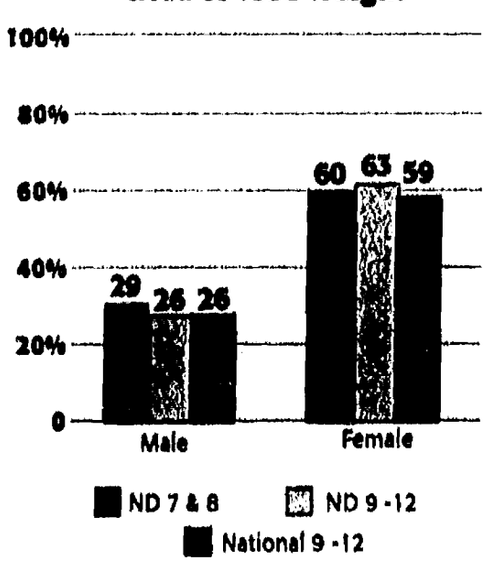
Ninth through 12th Grade: 65 percent of males and 61 percent of females were involved in a team sport run by the school.

Body Image/Weight Loss

Students who considered themselves "slightly" or "very" overweight

North Dakota 7&8 Grade	Males	28%
	Females	38%
North Dakota 9-12 Grade	Males	28%
	Females	41%

Students who have tried to lose weight



Students from North Dakota schools reported using the following methods to maintain their current weight or to lose weight in the 30 days prior to the survey

	Grade 7 & 8		Grade 9 -12	
	Males	Females	Males	Females
Exercise	53%	73%	44%	72%
Diet	26%	52%	21%	58%
Laxative/Vomit	3%	6%	3%	10%
Diet Pill/Powders/Liquids	4%	11%	3%	12%

Violence

In 1999, 12 percent of ninth through 12th grade students and 4 percent of seventh and eighth grade students reported carrying a weapon other than for hunting during the previous 30 days. Eight percent of ninth through 12th graders and 4 percent of seventh and eighth graders indicated that they had carried a weapon on school property during the same time period. A weapon is defined as a knife, gun or club.

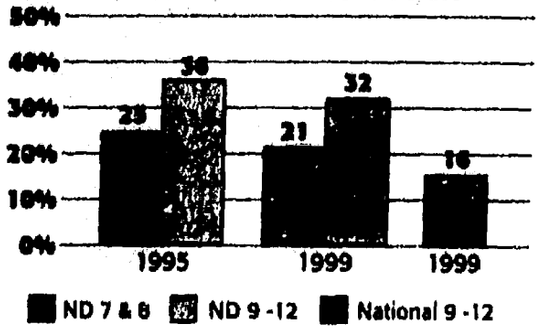
Students who were involved in a physical fight during the last 12 months

	Males	Females
North Dakota 7 & 8	42%	22%
North Dakota 9 -12	38%	22%
National 9-12	44%	27%

In 1998, North Dakota juveniles were involved in 42 weapons violations without more serious charges.[4]

Seat Belts/Helmets

Students who RARELY or NEVER wore a seat belt



In 1999, 71 percent of North Dakota high school students who rarely or never wore a seat belt admitted to riding with others who had been drinking.

Always wore a helmet

Bicycle	7 -12 Grade	2%
Rollerblade/Skateboard	7 & 8 Grade	3%
Motorcycle	9 -12 Grade	8%

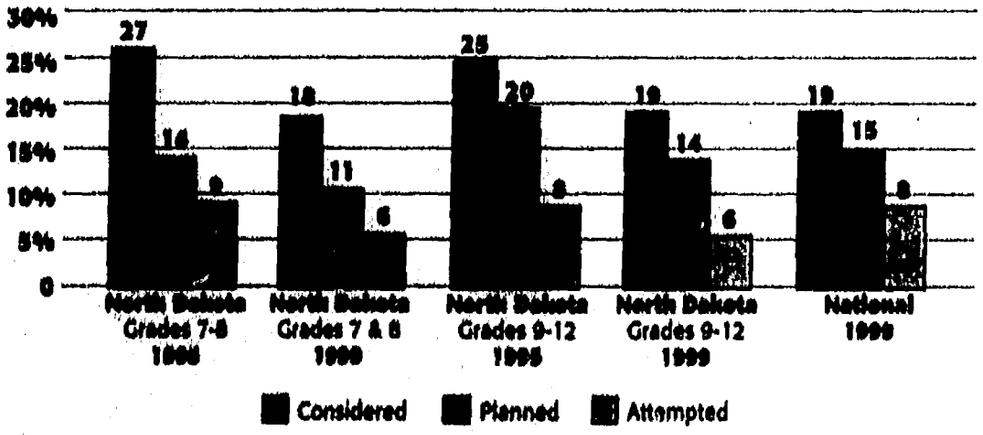
Suicide

In 1998, there were nine reported suicides among people younger than 20 in North Dakota; a large majority of these cases were teenage males.[5]

For adolescents 15 to 19 years of age, suicide is the second leading cause of death, and homicide is the third leading cause of death. While the suicide rate for the general population has remained relatively stable since the 1950s, the suicide rate for adolescents has more than tripled.[6]

Boys are more likely to commit suicide, but girls are more likely to consider and plan suicide. It is believed this is due to the method of choice: pill ingestion for females and firearms for males.[7] Homes with guns are 4.8 times more likely to experience the suicide of a resident than homes without guns.[8]

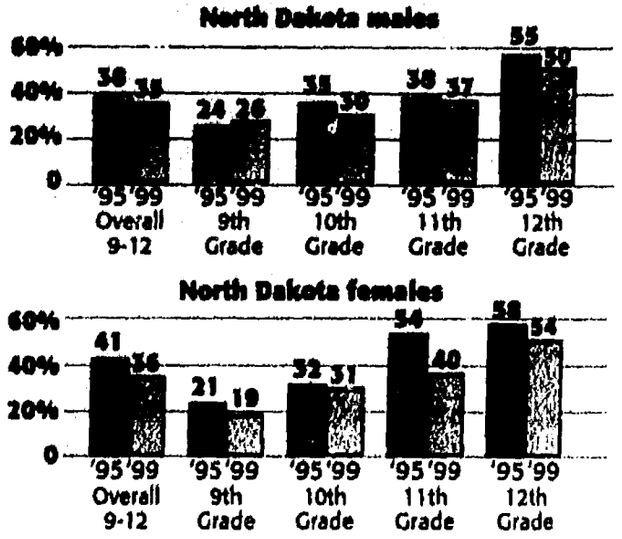
Seriously considered, planned or attempted suicide



Sexual Behavior

...ionally, 52 percent of male and 48 percent of female students grades nine through 12 have been sexually active during their lifetime.

Students in grades nine through 12 who reported intercourse during their lifetime.



In 1999, 35 percent of North Dakota students grades nine through 12 who have ever had sex reported drinking alcohol or using drugs before engaging in sexual intercourse; this compares to 25 percent nationally.

1998 North Dakota Teen Pregnancies[9]

There were 963 teen pregnancies and 781 live births among 12- through 19-year-olds.

Sex and Violence

Eleven percent of North Dakota students grades nine through 12 reported they had been hit, slapped or physically hurt on purpose by a boyfriend or girlfriend during the previous year.

Nine percent of high school students indicated they had been forced to have sexual intercourse when they did not want to. Females reported forced intercourse at twice the rate of males.

In North Dakota at least 66 percent of all sexual assault victims were younger than age 18 at the time of the assault(s).[14]

Sexually Transmitted Diseases/Infections

In North Dakota, 33 percent of all sexually transmitted diseases occur in 15- through 19-year-olds.[10]

Sexually transmitted diseases/infections reported in 15- to 19-year-olds[10]

	Chlamydia	Gonorrhea
1992	298	13
1993	254	9
1994	339	9
1995	320	10
1996	304	11
1997	276	26
1998	349	25
1999	307	30

HIV/AIDS

Only 58 percent of high school students who have ever had sex indicated they had used a condom the last time they had sexual intercourse.

Adolescents younger than age 15 were less likely to use condoms (47 percent) than older high school students (59 percent) the last time they had sexual intercourse.

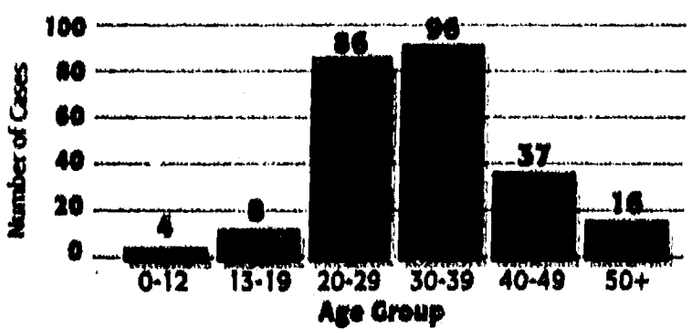
Even though AIDS incidence is declining, there has not been a comparable decline in the number of newly diagnosed HIV cases among youth. Scientists believe that cases of HIV infection reported among 13- through 24-year-olds are indicative of overall trends in HIV incidence because this age group has more recently initiated high-risk behaviors.[11] Teens infected with HIV often are not diagnosed until years later.

The Centers for Disease Control and Prevention estimates that between 120,000 and 160,000 adult and adolescent females are living with HIV infection in the United States.[12]

Age at HIV Diagnosis

North Dakota Cumulative Reported HIV Cases[13]

1984 through 1999
n=247



Primary Research Studies:

North Dakota Youth Risk Behavior Survey, North Dakota Department of Health and North Dakota Department of Public Instruction, 1995 and 1999.

Other Sources

1. Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, Atlanta, Ga., Vol. 49, 2000.
2. Chronic Diseases and Their Risk Factors: The Nation's Leading Causes of Death, Centers for Disease Control and Prevention, Atlanta, Ga., 1999.
3. Stanton A. Glantz, Ph.D., Tobacco Biology & Politics, HEALTH EDCO, 1992.
4. North Dakota Courts Annual Report, 1998.
5. North Dakota Drivers License and Traffic Safety Division, Department of Transportation, 2000.
6. Advance Report of Final Mortality Statistics, 1994. National Center for Health Statistics, Vol. 45, Supp. 3, 1996.
7. U.S. Bureau of Health & Human Service, National Center for Health Statistics, Vital Statistics of the United States (Washington D.C. USGPO, 1991) Vol. 2, Part A, 1988.
8. A.L. Kellerman, F.P. Rivera, et al., Suicide in the Home in Relationship to Gun Ownership, New England Journal of Medicine, Vol. 327, pp. 467-472, 1992.
9. North Dakota Vital Statistics on the Web, Division of Vital Records, North Dakota Department of Health. http://www.health.state.nd.us.
10. Sexually Transmitted Disease Report, Division of Disease Control, North Dakota Department of Health, 2000.
11. Young People at Risk: HIV/AIDS Among America's Youth, Centers for Disease Control and Prevention, August 1999. http://www.cdc.gov/hiv
12. HIV/AIDS Among U.S. Women: Minority and Young Women at Continuing Risk, Centers for Disease Control and Prevention, August 1999. http://www.cdc.gov/hiv
13. HIV/AIDS Surveillance Program, North Dakota Department of Health, 1999.
14. Sexual Assault Statistics, North Dakota Council on Abused Women's Services/Coalition Against Sexual Assault in North Dakota, January-June 1999.

No knowledge is more crucial than knowledge about health. Without it, no other life goal can be successfully achieved.

--Ernest L. Boyer (1983)

For more information contact:

North Dakota Department of Health
Division of Health Promotion
701.328.3138

North Dakota Department of Public Instruction
701.328.2753

April 2000

CDC's* Guidelines for School Health Programs to Prevent Tobacco Use and Addiction *were designed to help achieve national health and education goals. They were developed in collaboration with experts from 29 national, federal, and voluntary agencies and are based on an extensive review of research and practice.

Key Principles

School programs to prevent tobacco use and addiction will be most effective if they

- Prohibit tobacco use at all school facilities and events.
- Encourage and help students and staff to quit using tobacco.
- Provide developmentally appropriate instruction in grades K–12 that addresses the social and psychological causes of tobacco use.
- Are part of a coordinated school health program through which teachers, students, families, administrators, and community leaders deliver consistent messages about tobacco use.
- Are reinforced by community-wide efforts to prevent tobacco use and addiction.

Recommendations

The guidelines include seven recommendations for ensuring a quality school program to prevent tobacco use.

1 Policy

Develop and enforce a school policy on tobacco use. The policy—developed in collaboration with students, parents, school staff, health professionals, and school boards—should

- Prohibit students, staff, and visitors from using tobacco on school premises, in school vehicles, and at school functions.
- Prohibit tobacco advertising (e.g., on signs, T-shirts, or caps or through sponsorship of school events) in school buildings, at school functions, and in school publications.
- Require that all students receive instruction on avoiding tobacco use.
- Provide access and referral to cessation programs for students and staff.
- Help students who violate smoking policies to quit smoking rather than just punishing them.

2 Instruction

Provide instruction about the short- and long-term negative physiologic and social consequences of tobacco use, social influences on tobacco use, peer norms regarding tobacco use, and refusal skills. This instruction should

- Decrease the social acceptability of tobacco use and show that most young people do not smoke.
- Help students understand why young people start to use tobacco and identify more positive activities to meet their goals.

- **Develop students' skills** in assertiveness, goal setting, problem solving, and resisting pressure from the media and peers to use tobacco.

Programs that only discuss tobacco's harmful effects or attempt to instill fear do not prevent tobacco use.

3 Curriculum

Provide tobacco-use prevention education in grades K–12.

- This instruction should be introduced in elementary school and intensified in middle/junior high school, when students are exposed to older students who typically use tobacco at higher rates.
- Reinforcement throughout high school is essential to ensure that successes in preventing tobacco use do not dissipate over time.

4 Training

Provide program-specific training for teachers. The training should include reviewing the curriculum, modeling instructional activities, and providing opportunities to practice implementing the lessons. Well-trained peer leaders can be an important adjunct to teacher-led instruction.

5 Family Involvement

Involve parents or families in support of school-based programs to prevent tobacco use. Schools should

- Promote discussions at home about tobacco use by assigning homework and projects that involve families.
- Encourage parents to participate in community efforts to prevent tobacco use and addiction.

6 Tobacco Cessation Efforts

Support cessation efforts among students and school staff who use tobacco. Schools should provide access to cessation programs that help students and staff stop using tobacco rather than punishing them for violating tobacco-use policies.

7 Evaluation

Assess the tobacco-use prevention program at regular intervals. Schools can use CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction* to assess whether they are providing effective policies, curricula, training, and cessation programs.

This brochure and the complete text of CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction* can be reproduced and adapted without permission. The guidelines and this brochure are on the Internet at http://www.cdc.gov/nccdphp/dash. (Click on "Strategies" and then select "School Health Programs.") Print copies are available from: CDC, Division of Adolescent and School Health, ATTN: Resource Room, 4770 Buford Highway, Mailstop K-32, Atlanta, GA 30341-3724; phone: (770) 488-3082. CDC's Division of Adolescent and School Health also distributes guidelines for school health programs to prevent the spread of AIDS, to promote healthy eating, and to promote physical activity.

Safe and Drug Free Schools and Communities Final Report Summary

School 99/2000 — **Total Number of Schools: 129**

Curriculum Used

K-6		6-8		9-12	
Character Count	67	Character Count	56	Curriculum Infusion	35
Curriculum Infusion	23	Curriculum Infusion	25	Discover	14
DARE	14	DARE	10	Locally Developed Curriculum	70
Discover	45	Discover	33	Life Skills Training	24
Duso	20	Get Real About Violence	1	Skills for Living	14
Get Real About Violence	1	Here's Looking at You 2000	6	Towards no Tobacco Use	6
Here's Looking at You 2000	6	Locally Developed Curriculum	62	PASS	3
Health Skills	25	Life Skills Training	38	Other Curriculum	35
Know Your Body	11	Project Alert	10		
Locally Developed Curriculum	61	Project Northland	0		
Learning to Live Drug Free	9	Quest	14		
Life Skills Training	20	Skills for Adolescence	19		
Operation Aware	4	Skills for Growing	8		
Skills for Growing	12	Towards No Tobacco Use	16		
ards No Tobacco Use	11	PASS	7		
Other Curriculum	39	Other Curriculum	33		

Authorized Activities

Teacher Staff Training - Drug Prevention	88
Teacher Staff Training - Violence Prevention	98
Student Instruction - Drug Prevention	107
Student Instruction - Violence Prevention	95
Curriculum Development	77
Student Assistance Program	71
Alternative Education Programs	25
Parent Education Involvement	76
After School/Before School Programs	40
Community Service Projects	48
Services for Out-of-School Youth	12
Speakers and Assemblies	81
Conflict Resolution/Peer Mediation	51
urity Personnel	15
Security Equipment	14
Grant Administration	21

Community Involvement

Joint Service Delivery	91
Teacher/Staff Training	100
Public Awareness Acttivity	108
Fundraising	36

Gun Free Schools

Implemented Firearm Policy	129
Number of firearm expulsions	0

Student participation in d slaming, delivering, or critiquing drug or viol ce prevention programming. 99

Safe and Drug Free Schools and Communities Final Report Summary

by Consortium 99/2000 — **Total Number of Consortiums: 23**

Curriculum Used

K-6		6-8		9-12	
Character Count	13	Character Count	11	Curriculum Infusion	13
Curriculum Infusion	8	Curriculum Infusion	11	Discover	3
DARE	3	DARE	0	Locally Developed Curriculum	10
Discover	9	Discover	8	Life Skills Training	5
Duso	1	Get Real About Violence	1	Skills for Living	5
Get Real About Violence	0	Here's Looking at You 2000	0	Towards no Tobacco Use	5
Here's Looking at You 2000	2	Locally Developed Curriculum	9	PASS	1
Health Skills	3	Life Skills Training	12	Other Curriculum	7
Know Your Body	5	Project Alert	6		
Locally Developed Curriculum	11	Project Northland	1		
Learning to Live Drug Free	3	Quest	4		
Life Skills Training	8	Skills for Adolescence	3		
Operation Aware	3	Skills for Growing	2		
Skills for Growing	3	Towards No Tobacco Use	7		
Towards No Tobacco Use	5	PASS	4		
Other Curriculum	6	Other Curriculum	4		

Authorized Activities

Teacher Staff Training - Drug Prevention	16
Teacher Staff Training - Violence Prevention	15
Student Instruction - Drug Prevention	21
Student Instruction - Violence Prevention	15
Curriculum Development	13
Student Assistance Program	9
Alternative Education Programs	4
Parent Education Involvement	16
After School/Before School Programs	6
Community Service Projects	8
Services for Out-of-School Youth	3
Speakers and Assemblies	16
Conflict Resolution/Peer Mediation	11
Security Personnel	2
Security Equipment	1
Grant Administration	10

Community Involvement

Joint Service Delivery	19
Teacher/Staff Training	22
Public Awareness Acttivity	22
Fundraising	4

Gun Free Schools

Implemented Firearm Policy	23
Number of firearm expulsions	0

Student participation in designing, delivering, or critiquing drug or violence prevention programming. 21

Safe and Drug Free Schools and Communities Final Report Summary 99/2000
Progress Report on Performance Indicators From Objectives

Goal 1: To improve PK-12 student knowledge and attitude toward safety as well as prevent or decrease the incidence of violent behavior.

To increase student knowledge of effects of violence.	To create a positive school climate.	To enforce school policies designed to deter violence.	Other
+ 99	+ 85	+ 65	+ 17
- 5	- 8	- 11	- 1
0 8	0 7	0 11	0 0
x 38	x 50	x 63	x 132

Goal 2: To improve PK-12 student knowledge and attitude toward alcohol, tobacco, and other drugs (ATOD) prevention as well as prevent, delay, or decrease ATOD use.

To increase positive student knowledge and attitude toward prevention.	To increase skills-based education for prevention.	Other	
+ 98	+ 76	+ 21	
- 9	- 8	- 5	
0 21	0 11	0 1	
x 22	x 55	x 123	

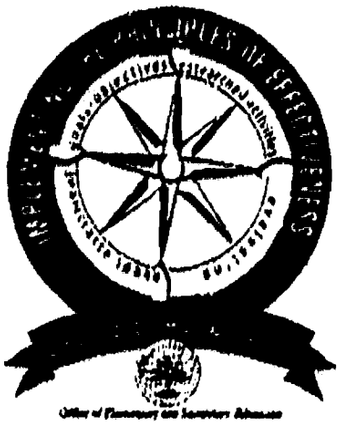
Goal 3: To improve staff knowledge and attitude toward prevention and promote practice of positive role modeling by staff for violence and ATOD prevention.

To promote awareness of programs on ATOD and violence prevention.	To increase knowledge of prevention strategies.	Other	
+ 99	+ 86	+ 18	
- 2	- 5	- 1	
0 5	0 7	0 0	
x 44	x 52	x 131	

Goal 4: To improve parent and community knowledge and attitude toward prevention as well as to promote involvement in violence and ATOD prevention.

To increase parent/community knowledge of approaches to prevention.	To recognize the need to be involved in prevention.	To disseminate information about drug and violence prevention programs, projects, and activities.	Other
+ 77	+ 65	+ 76	+ 5
- 5	- 4	- 2	- 1
0 11	0 7	0 9	0 0
x 57	x 74	x 63	x 144

KEY: **+ Improved - Declined 0 No Change x Not Addressed**



PRINCIPLES OF EFFECTIVENESS

The Department of Education has announced that the following Principles of Effectiveness will govern recipients' use of fiscal year 1998 and future years' funds received under Title IV - State and local programs of the Elementary and Secondary Education Act—the Safe and Drug-Free Schools and Communities Act (SDFSCA) State Grants Program. The Principles of Effectiveness take effect on July 1, 1998.

Principle 1: ***Conducting Needs Assessments***	**Principle 2:** ***Setting Measurable Goals and Objectives***
A grant recipient shall base its program on a thorough assessment of objective data about the drug and violence problems in the schools and communities served.	A grant recipient shall, with the assistance of a local or regional advisory council, which includes community representatives, establish a set of measurable goals and objectives, and design its activities to meet those goals and objectives.

Principle 3: ***Effective Research-Based Programs***	**Principle 4:** ***Program Evaluation***
A grant recipient shall design and implement its activities based on research or evaluation that provides evidence that the strategies used prevent or reduce drug use, violence, or disruptive behavior.	A grant recipient shall evaluate its program periodically to assess its progress toward achieving its goals and objectives and use its evaluation results to refine, improve, and strengthen its program and to refine its goals and objectives as appropriate.

(The four Principles of Effectiveness, as posted in the *Federal Register* of June 1, 1998.)

SB 2380
Providing Comprehensive Tobacco Prevention
American Heart Association Position of Support

The American Heart Association supports the funding of a comprehensive tobacco prevention and cessation program for North Dakota. In the past two years we have been receiving millions of dollars through the tobacco settlement for the cost of tobacco addiction in our state. During that same time, our youth experimentation rate with tobacco has increased to 40.6%, establishing North Dakota as a state with the third highest use rate in the nation. Other states meanwhile have invested in comprehensive efforts and have significantly reduced their youth consumption. By not addressing our tobacco problem in North Dakota, we are committing our future to:

- Higher taxes to pay for medical costs
- Higher health insurance coverage
- Higher costs for businesses and service providers
- Higher employee sick days
- Higher death lost to tobacco related diseases

All states receive federal funding that enables a basic structure of educated specialists to be in place. It is well documented that additional state investment into a comprehensive program is needed to reduce youth use and to help addicted smokers to quit. Those funds have been provided in other states through either the tobacco settlement, or through increased cigarette excise taxes.

No comprehensive program has yet to fail in reducing tobacco use. A recent Washington State study demonstrated that when funds are spent on non-comprehensive, non-evidence based efforts, youth consumption won't decrease dramatically. That is why it is important for the legislature to ensure state dollars are spent only on proven interventions.

We urge your support for this bill.

SB 2380

American Heart Association.

Fighting Heart Disease and Stroke

PROPOSED AMENDMENTS TO ENGROSSED SB2380
Alternate Appropriations Language

Page 7, line 3, after "fund", delete "Of", and on line 4, after "fund" insert "shall be used for tobacco prevention and cessation efforts as outlined in section 6. Grants that are awarded should include programs with an emphasis on healthy school and health community approaches."

Page 7, line 5, remove "The first", and after "dollars" insert "deposited in the Tobacco Settlement Trust Fund", and replace "used" with "available for use".

Page 7, line 6, after "emergencies" remove "and to provide funding for the grant programs established under this subsection, if necessary, based upon the anticipated timing of transfers to be received from the tobacco settlement trust fund".

Page 7, line 10, after "units" insert "for purposes outlined in Section 6 of this Act.".

Page 7, line 11, remove "An amount not to exceed two million dollars must be used to fund".

Page 7, line 13, after "programs" insert "will be included to the extent outlined in Section 6 of this Act".

Page 7, line 14, remove "An amount not to exceed two million dollars must be used to fund", and insert on line 15, after programs "will be included to the extent outlined in Section 6 of this Act".

Page 7, remove line 15, starting with "The eligibility criteria....." and ending with "ordinances." on line 18.

Page 7, line 19, replace "An amount not to exceed seven hundred fifty thousand dollars" with "A portion of the funds, to the extent outlined in Section 6 of this Act."

Page 7, line 21, replace "An amount not to exceed two hundred fifty thousand dollars" with "A portion of the funds, to the extent outlined in Section 6 of this Act."

Page 7, line 29, replace "this Act" with "a tobacco prevention and dependency treatment"

Renumber accordingly

Intent:

The amendments provides the committee flexibility to direct funds to the most effective strategies and proposals, while holding them accountable to directing funding to local health units, communities and schools. It also addresses the other concerns outlined in the first recommended appropriations amendments.

SB 2380

American Heart Association.

Fighting Heart Disease and Stroke

PROPOSED AMENDMENTS TO ENGROSSED SB2380
Appropriation of Health Trust Funds

Page 7, line 3, after "fund", delete "Of", and on line 4, after "fund" insert "shall be used for tobacco prevention and cessation efforts as outlined in section 6. Grants that are awarded should include programs with an emphasis on healthy school and health community approaches."

Page 7, remove lines 5 – 24.

Page 7, line 26, remove "not otherwise appropriated",

Page 7, line 29, replace "this Act." with "a tobacco prevention plan"

Renumber accordingly

Intent

The amendments provide a threshold of funding comparable to some of the other states now demonstrating successes in reducing tobacco use. In addition, given that the $5.2 appropriation is below the recommended minimum levels recommended by the CDC, flexibility for the committee in meeting the objectives of Section 6 is critical.

As currently written this bill directs all health trust funds to non-tobacco prevention efforts, leaving little, if anything for the tobacco prevention fund. It also raises concern that the language may jeopardize the federal tobacco prevention funds by potential changes in use of the dollars.

Granted, other public health needs exists. Solutions may exist through exploring uses of the Health Care Trust Fund, or reconsideration of the overall division of tobacco settlement dollars. Adequate tobacco prevention and cessation appropriations are needed in order to begin reducing the financial impact to the state and local taxpayer before settlement payments discontinue.

American Heart Association...
Fighting Heart Disease and Stroke

SB 2380 Testimony

June Herman, American Heart Association

SB 2380 provides North Dakota with a first step opportunity to begin an effective tobacco prevention and cessation program.

We support suggested amendments that accelerate the development and implementation of a North Dakota plan, and the amendments that remove the funding categories. Such steps place the responsibility, and the ability to develop a plan into the hands of the advisory committee being established by SB 2380. It allows the committee to adjust for:

- Commitments from DPI and Human Services to continue $1.5 million in related efforts
- A competitive grant process, through which communities can propose matches and pilot programs when possible, or allowing for other communities to propose grants through which collaboration with youth, tobacco prevention specialists, and others is achieved.
- Provides for funding decisions that balance statewide and local economies of scale.

Funding:

- Health trust fund use for tobacco prevention and cessation efforts can place us in a category similar to states achieving success
- Coordination with the $1.5 million from DPI/Human Services places us within the range of the minimum benchmark established by CDC.

PER-CAPITA STATE SPENDING FOR COMPREHENSIVE TOBACCO PREVENTION

State	Reduction Results	Per Capita Funding	Percent of CDC's Low Recommendation	Program Status
Massachusetts	Dropped 33%. Youth sales dropped from 48% to 8%.	$8.67	150.9%	Existing & New Allocation
California	Dropped 2X the national average.	$3.90	76.2%	Existing Program
Florida	Middle school use rate dropped from 18.9% to 8.6%. High school -- from 27.4% to 20.9%*	$3.30	56.1%	Existing Program
Oregon	11% Drop	$2.62	40.2%	Existing Program
ND - Plan		$5.72	44.9%	Proposed

American Heart Association...
Fighting Heart Disease and Stroke

SB 2380 Testimony

June Herman, American Heart Association

SB 2380 provides North Dakota with a first step opportunity to begin an effective tobacco prevention and cessation program.

Funding:

- Appropriating the full Health Trust Fund for tobacco prevention and cessation efforts can place us in a category similar to other states achieving success

PER-CAPITA STATE SPENDING FOR COMPREHENSIVE TOBACCO PREVENTION

State	Reduction Results	Per Capita Funding	Percent of CDC's Low Recommendation	Program Status
Massachusetts	Dropped 33%. Youth sales dropped from 48% to 8%.	$8.67	150.5%	Existing & New Allocation
California	Dropped 2X the national average.	$3.90	76.2%	Existing Program
Florida	Middle school use rate dropped from 18.5% to 8.6%. High school – from 27.4% to 20.9%*	$3.00	56.1%	Existing Program
Oregon	11% Drop	$2.62	40.2%	Existing Program
ND – Plan*		$5.48	43%	Proposed

* $4,700,000 million Health Trust fund; $2,369,934 million - CDC

Areas for committee consideration:

It is important to note that initial funding reaches roughly half of the recommended model CDC program. As such, it is important to fund those proposals that can best demonstrate the impact tobacco prevention and cessation programs can have in our state. For that reason, we have the following comments regarding the appropriation language in the bill:

1) **We encourage that specific funding categories be eliminated.** This places the ability to develop a comprehensive plan in the hands of the advisory committee being established by SB 2380. It allows the committee to prioritize grants to reflect changes in funding and emerging best practices, while continuing to build for a statewide comprehensive program.

2) **Appropriate according to a competitive grant process.** Public health units will be a natural and important partner for a comprehensive program. Keeping the grants competitive however, encourages communities to continually stay abreast of best practices, other community approaches, and as a result, build even stronger community support for addressing tobacco use issues.

3) **Provide the opportunity for both local community and statewide grants.** Rather than distribute the funds only through health units, distribute the funds through the state health department and a competitive grant process that also accommodates statewide approaches or combinations of local/state proposals. As examples:
   a) The 4-H extension office spoke to the interim committee on this issue in regard to using their statewide youth network.
   b) A statewide 1-800 quit line could be proposed, at greater cost efficiencies.
   c) Youth driven media messages: developed by youth at the local level, with top messages promoted through a statewide media package.
   d) College/University Targeted Grants: separate and coordinated efforts planned and implemented.

Tobacco use in North Dakota is the leading preventable risk factor, and we can do something about it. Investing this session in an effective program will keep more of our youth from starting to smoke and will reduce future costs to the individual taxpayer, businesses and families.

AMERICAN LUNG ASSOCIATION®
of North Dakota

212 North 2nd Street • P.O. Box 5004 • Bismarck, ND 58502
(701) 223-5613 • 1-800-ALA-NDAK

Susan Kahler
Executive Director of American Lung Assn. of North Dakota
PO Box 5004
Bismarck, ND 58502
701-223-5613

Chairman and committee members,

The American Lung Association of North Dakota supports allocating a significant portion of state settlement funds to effective comprehensive tobacco prevention and treatment programs. This comprehensive tobacco plan was developed and studied by the Center for Disease Control with proven components that scientifically show a reduction in smoking rates when all components are funded.

To counter the immense power of the tobacco industry, it is critical that comprehensive tobacco prevention programs empower community partners to engage in activities that reduce the influence of the tobacco companies. Integrated with the other elements of a comprehensive campaign -- public education, school based programs, adult and teen cessation programs, indoor air laws and strict youth access laws -- community based efforts can contribute to reductions in tobacco use.

The following states made an investment in a tobacco comprehensive plan and here are there results:

(1999 study by the University of Illinois at Chicago found that "comprehensive tobacco control programs are in fact the 'best buy' for reducing teenage smoking.")

- **Florida's statewide anti-tobacco campaign was funded by its 1997 settlement with the tobacco industry. The program is targeted at youth and combines a counter-marketing media campaign, community-based activities, education and training and an enforcement programs. Result: Tobacco use in Florida among middle school students declined by 21 percent and among high school students declined by 8 percent between 1998 and 1999.**

- **Massachusetts implemented a comprehensive tobacco control program in 1993, funded by an increase in the cigarette tax of 25 cents per pack. Result: A decrease in tobacco use by both adults and children. Overall cigarette consumption in Massachusetts has declined by 30 percent since 1992. Between 1995 and 1999, current smoking among Massachusetts's high school students was reduced by 15 percent.**

- **California launched its Tobacco Control Program in the Spring of 1990. The Program is funded with money from Proposition 99, a ballot initiative that increased the cigarette excise tax by 25 cents per pack. Results: Since passage of Proposition 99, cigarette consumption in California has decline by 38 percent. More than 1.3 million Californians have quit smoking because of the California program. A 14% decrease in lung cancer over the past 10 years.**

These are just a few success stories of states who made an investment in a tobacco comprehensive program and they have shown results. North Dakota has an opportunity to invest the tobacco settlement dollars into a comprehensive tobacco program for our state to decrease our smoking rates, especially the youth who are ranked 3rd in our nation. We need to address the youth as well as the adults to decrease the smoking rates.

Reason Why we need a comprehensive plan.

1. Texas just newsrelease on January 23, 2001. The state of Texas released important new evidence that comprehensive tobacco prevention programs work to reduce tobacco use among youth and are far more effective than piecemeal prevention efforts. Rather than spending substantial tobacco settlement funds to implement a statewide tobacco prevention program, Texas in 1999 allocated only a small amount to implement pilot tobacco prevention programs of varying levels in 14 East Texas communities. Results released on January 23, 2001 by a team of independent evaluators from several Texas universities show that truly comprehensive programs are by far the most effective. Communities with more comprehensive programs reduce tobacco use among 6th graders at up to twice the rate as communities with more limited approaches.

2. Hutchinson Smoking Prevention Project This is a perfect example of just implementing one component of a comprehensive plan. CDC recommends that school-based programs, in order to be effective, need to involve much more than classroom curriculum alone. Curricula need to be implemented within the broader context of strictly enforced school tobacco-free policies, active parent and community involvement, and cessation services for students and staff, and the need to be coordinated with community and media efforts to reduce tobacco use.

These are examples of states that tried to partially implement programs without spending the funds to provide a comprehensive program.

Thank you for your time and I will try to answer your questions.

Susan Kahler

Bruce Levi
ND Medical Association

Testimony on SB 2380
Senate Human Services Committee
January 31, 2001

Last fall, North Dakota's physicians through NDMA's House of Delegates adopted a resolution supporting the development in North Dakota of a science-based, comprehensive tobacco prevention and dependence treatment program, using one-third of the tobacco settlement funds for this purpose.

In coming to that conclusion, physicians relied on the following points:

The use of tobacco products by North Dakota citizens has resulted in devastating health and economic consequences, including 1050 deaths each year, and healthcare expenditures of over $180 million (over 11% of all health care expenditures in North Dakota) -- the burden being imposed on taxpayers, businesses, individuals, and government.

Tobacco companies spend $12 million annually advertising their products in North Dakota, influencing more than 22% of our citizens to smoke and chew tobacco and giving our state the third worst national ranking in per capita death rate, as well as the third highest youth smoking rate in the nation.

Primary care physicians in North Dakota are in the unique position of seeing the tragic effects of smoking and second-hand smoke in their patients on a daily basis, including cases of heart disease, lung cancer, emphysema, bronchitis, pneumonia, sinusitis, and ear infections in both adults and children.

The North Dakota Chapters of the American Academy of Family Physicians, the American Academy of Pediatrics, and the American College of Physicians – American Society of Internal Medicine have each given their support to a strong tobacco education and prevention program in North Dakota.

The U.S. Centers for Disease Control has developed a science-based approach to tobacco prevention and cessation illustrating "best practices" strategies and programs to be implemented on a state-wide basis, including community programs to reduce tobacco use, chronic disease programs, school programs, enforcement efforts, statewide programs, countermarketing, and cessation programs.

Research shows that these best practice strategies are most effective when they are all integrated into a comprehensive program. The experience in other states with comprehensive programs such as Massachusetts, California, Oregon and Florida shows that, when adequately funded, these comprehensive programs can quickly and substantially reduce tobacco use.

We encourage the committee to take steps to begin development in North Dakota of a *comprehensive* approach to tobacco prevention. While the language in SB 2380 supports a

comprehensive approach (p. 3, line 29 through p. 4, line 4), the implementation language is devoted entirely to "youth smoking" prevention, including the composition of the proposed commission, the scope of the ongoing planning process, and the grants that would be made available.

The Surgeon General of the United States, as well as the Centers for Disease Control, have documented evidence showing that multi-faceted, state-based tobacco control programs are effective in reducing tobacco use. According to the 2000 Surgeon General's Report: *Reducing Tobacco Use*, the components of a multi-faceted approach include: (1) community interventions, which include diverse entities such as schools, health agencies, city and county governments, and civic, social, and recreation organizations, (2) countermarketing, which includes using media advocacy, paid media, prohealth promotions, and other media strategies to change social norms regarding tobacco use, (3) program policy and regulation, which addresses such issues as minors' access, tobacco pricing, advertising and promotion, clean indoor air, product regulation, and tobacco use cessation, and (4) surveillance and evaluation, which includes monitoring tobacco industry promotional campaigns, evaluating the economic impact of environmental tobacco smoke (ETS) laws and policies, conducting surveys of of public opinion on program interventions, and other activities to make ongoing refinements that lead to more effective prevention strategies.

The Surgeon General's report notes that the synergy created by the interaction of various program components in a comprehensive approach is believed to be responsible for increased success in reducing tobacco use. The report states, in addressing the need for comprehensive approaches:

> The evidence of effectiveness summarized in this report emphasizes that public health success in reducing tobacco use requires activity using multiple modalities. A comprehensive approach – one that optimizes synergy from applying a mix of educational, clinical, regulatory, economic, and social strategies – has emerged as the guiding principle for future efforts to reduce tobacco use. The public health goals of such comprehensive programs are to reduce disease, disability, and death related to tobacco use through prevention and cessation, as well as through protection of the nonsmoker from ETS.

The emerging body of data on statewide tobacco control efforts is coming from programs broadly focused on prevention, cessation, and protection of the nonsmoker from ETS. Preventing initiation among young people is a primary goal of any tobacco control effort. However, young people will perceive contradictory or inconsistent messages in our prevention efforts if programs do not also address the smoking behavior of millions of parents and other adult role models and the public health risks of ETS.

Attached to this testimony are copies of relevant portions of the 2000 Surgeon General's Report, *Reducing Tobacco Use*, which also includes specific descriptions of major programs developed in Minnesota, California, Massachusetts, Arizona, Oregon, Maine, Mississippi, Florida, and Texas. Also included are reports generated from a panel convened by the former Attorney General, in an effort that involved a number of physicians in identifying a comprehensive, science-based approach to tobacco prevention and dependency treatment in North Dakota. We urge you to review the documents, which describe the merits of a comprehensive approach.

Also attached are proposed amendments to SB 2380, which would revise the provisions of the bill, including the commission structure and scope of grant authority, to recognize a more comprehensive approach to tobacco prevention in our state.

The North Dakota Medical Association stands ready to provide information and technical assistance from physicians if necessary to assist the committee. We urge the Committee to consider the proposed amendments to SB 2380.

ND Medical Association

Bruce Levi

PROPOSED AMENDMENTS TO SB 2380

Page 1, line 1, replace "youth smoking" with "tobacco"
Page 1, line 5, replace "youth smoking" with "tobacco"
Page 1, line 7, replace "youth smoking" with "tobacco"
Page 1, line 10, replace "2001" with "1999"
Page 1, line 12, replace "youth smoking" with "tobacco"
Page 1, line 15, replace "youth smoking" with "tobacco"
Page 1, line 16, replace "**Youth smoking**" with "**Tobacco**"
Page 1, line 17, replace "youth smoking" with "tobacco"
Page 1, replace lines 21 through 23 with:

"c. The attorney general or the attorney general's designee.

d. One member representing Native Americans, appointed by the governor from a list consisting of a nominee provided by each of the tribal councils in North Dakota.

e. One youth member who must be under age eighteen at the time of nomination, appointed by the governor.

f. One representative of nongovernmental, voluntary tobacco control organizations, appointed by the governor.

g. One member of the local public health community, appointed by the governor from a list provided by the North Dakota public health association.

h. The superintendent of public instruction or the superintendent's designee.

i. The state health officer or the state health officer's designee, which may include the state tobacco prevention control coordinator employed by the health department.

j. An academic researcher with expertise in tobacco control and health promotion intervention appointed by the dean of the university of North Dakota medical school.

k. One physician appointed by the governor."

Page 2, remove lines 1 through 5

Page 3, line 4, replace "**Youth prevention**" with "**Tobacco**"
Page 3, line 5, replace "youth smoking" with "tobacco"
Page 3, line 6, after "of" insert "one-third of the"
Page 3, line 7, remove "for the purpose of the prevention of youth smoking"
Page 3, line 16, replace "**youth smoking**" with "**tobacco**" and after "**prevention**" insert "**and dependency treatment**"
Page 3, line 17, replace "youth" with "tobacco"
Page 3, line 18, remove "smoking" and after "prevention" insert "dependency treatment"

Page 4, line 9, replace "youth smoking" with "tobacco" and after "prevention" insert "and dependency treatment"
Page 4, line 10, replace "The eligible programs must" with "The commission must give priority to programs that are:

a. Research based or based on proven effective strategies;

b. Designed to coordinate with other activities and education messages related to other health activities;
c. Utilize and enhance existing prevention and treatment activities and resources; or
d. Involve innovative approaches for the prevention of tobacco use."

Page 4, remove lines 11 through 21
Page 4, line 22, replace "4." with "3." and replace "school-based survey to" with "assessment of tobacco-related behaviors and attitudes among youth to establish a baseline to measure statewide effects of tobacco use prevention and treatment activities. To the extent feasible, the assessment should be conducted so that the results may be compared to nationwide data."
Page 4, remove lines 23 through 27
Page 4, line 28, replace "c. Be" with "The assessment must be"

Page 5, remove lines 1 and 2
Page 5, line 3, replace "6." with "4."
Page 5, line 5, replace "youth smoking" with "tobacco"
Page 5, line 6, replace "youth smoking" with "tobacco"
Page 5, line 10, replace "youth" with "tobacco"
Page 5, line 11, remove "smoking"
Page 5, line 12, replace "youth smoking" with "tobacco"
Page 5, line 16, replace "youth smoking" with "tobacco"
Page 5, line 19, replace "youth smoking" with "tobacco"
Page 5, remove lines 26 through 30

Page 6, remove lines 1 through 19
Page 6, line 20, replace "6." with "4."
Page 6, line 24, replace "youth smoking" with "tobacco" and after "prevention" insert "dependency treatment"
Page 6, line 25, remove "youth"
Page 6, line 26, remove "smoking prevention"

Page 7, line 10, replace "youth" with "individuals"
Page 7, line 27, replace "state department of health" with "tobacco prevention fund"
Page 7, line 28, replace "youth smoking" with "tobacco"
Page 7, line 29, replace "youth smoking" with "tobacco"

Renumber accordingly

Comprehensive Programs Fact Sheet

RATIONALE FOR COMPREHENSIVE INTERVENTIONS

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

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

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

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

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

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

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

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

CDC'S NATIONAL TOBACCO CONTROL PROGRAM

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

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

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

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

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

Reducing Tobacco Use

A Report of the Surgeon General - 2000

At A Glance

Tobacco use, particularly smoking, remains the number one cause of preventable disease and death in the United States. This report of the Surgeon General on smoking and health is the first to offer a composite review of the various methods used to reduce and prevent tobacco use. The topic is a new one in this series of reports, although previous reports have looked at aspects of such strategies. This report evaluates each of five major approaches to reducing tobacco use: educational, clinical, regulatory, economic, and comprehensive. Further, the report attempts to place the approaches in the larger context of tobacco control, providing a vision for the future of tobacco use prevention and control based on these available tools. The report is clear in its overriding conclusion: *Although our knowledge about tobacco control remains imperfect, we know more than enough to act now.*

> *"If the recommendations in this report were fully implemented, the* Healthy People 2010 *objectives related to tobacco use could be met, including cutting in half the rates of tobacco use among young people and adults. It is clear that the major barrier to more rapid reductions in tobacco use is the effort of the tobacco industry to promote the use of tobacco products. Our lack of greater progress in tobacco control is more the result of failure to implement proven strategies than it is the lack of knowledge about what to do. As a result, each year, more than 1 million young people continue to become regular smokers and more than 400,000 adults die from tobacco-related diseases. Tobacco use will remain the leading cause of preventable illness and death in this Nation and a growing number of other countries until tobacco prevention and control efforts are commensurate with the harm caused by tobacco use."*
>
> –David Satcher, MD, PhD, Surgeon General

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Office on Smoking and Health

Major Conclusions of the Surgeon General's Report

- ▲ Efforts to prevent the onset or continuance of tobacco use face the pervasive, countervailing influence of tobacco promotion by the tobacco industry, a promotion that takes place despite overwhelming evidence of adverse health effects from tobacco use.
- ▲ The available approaches to reducing tobacco use--educational, clinical, regulatory, economic, and comprehensive--differ substantially in their techniques and in the metric by which success can be measured. A hierarchy of effectiveness is difficult to construct.
- ▲ Approaches with the largest span of impact (economic, regulatory, and comprehensive) are likely to have the greatest long-term, population impact. Those with a smaller span of impact (educational and clinical) are of greater importance in helping individuals resist or abandon the use of tobacco.
- ▲ Each of the modalities reviewed provides evidence of effectiveness.
  - Educational strategies, conducted in conjunction with community- and media-based activities, can postpone or prevent smoking onset in 20 to 40 percent of adolescents.
  - Pharmacologic treatment of nicotine addiction, combined with behavioral support, will enable 20 to 25 percent of users to remain abstinent at one year posttreatment. Even less intense measures, such as physicians advising their patients to quit smoking, can produce cessation proportions of 5 to 10 percent.
  - Regulation of advertising and promotion, particularly that directed at young people, is very likely to reduce both prevalence and uptake of tobacco use.
  - Clean air regulations and restriction of minors' access to tobacco products contribute to a changing social norm with regard to smoking and may influence prevalence directly.
  - An optimal level of excise taxation on tobacco products will reduce the prevalence of smoking, the consumption of tobacco, and the long-term health consequences of tobacco use.
- ▲ The impact of these various efforts, as measured with a variety of techniques, is likely to be underestimated because of the synergistic effect of these modalities. The potential for combined effects underscores the need for comprehensive approaches.
- ▲ State tobacco control programs, funded by excise taxes on tobacco products and settlements with the tobacco industry, have produced early, encouraging evidence of the efficacy of the comprehensive approach to reducing tobacco use.

Reducing Tobacco Use, A Report of the Surgeon General, appears at a time of considerable upheaval in efforts to control and prevent tobacco use. Legal and legislative efforts to protect children from tobacco initiation and to reduce smoking among adults are in a state of flux, with some important gains and some sobering setbacks. Major changes in the public stance of the tobacco industry have evoked a reevaluation of strategies for controlling and preventing tobacco uptake. Enormous monetary settlements have provided the resources to fuel major new comprehensive anti-tobacco efforts, but the ultimate cost and benefit of these resources are still to be determined. Into this changing landscape, this report introduces an assessment of information about the value and efficacy of the major approaches that have been used to reduce tobacco use: educational, clinical, regulatory, economic, and comprehensive.

Widespread dissemination of the approaches and methods shown to be effective, especially in combination, would substantially reduce the number of young people who will become addicted to tobacco, increase the success rate of young people and adults trying to quit using tobacco, decrease the level of exposure of nonsmokers to environmental tobacco smoke, reduce the disparities related to tobacco use and its health effects among different population groups, and decrease the future health burden of tobacco-related disease and death in this country.

What We Know

This Surgeon General's report provides evidence that tobacco use in this nation can be reduced through existing types of interventions, in line with health objectives detailed in *Healthy People 2010*. Attaining these objectives will almost certainly require significant national commitment to using the various successful approaches described in the report.

Educational Strategies

More consistent implementation of effective educational strategies to prevent tobacco use will require continuing efforts to build strong, multi-year prevention units into school health education curricula and expanded efforts to make use of the influence of parents, the mass media, and other community resources.

School-based programs can have a significant impact on smoking behavior among young people and are

most effective when part of a comprehensive, community-based effort. Implementing effective school-based programs–along with community and media-based activities–can prevent or postpone smoking onset in 20 to 40 percent of U.S. adolescents. Unfortunately, less than 5 percent of schools nationwide have implemented the major components of CDC's recommended guidelines for school-based programs to prevent tobacco use.

Management of Nicotine Addiction

The vast majority of smokers in the United States want to quit, but only a little more than 2 percent successfully quit each year. Tobacco dependence is in fact best viewed as a chronic disease with remission and relapse. Even though both minimal and intensive interventions increase smoking cessation, most people who quit smoking with the aid of such interventions will eventually relapse. Moreover, there is little understanding of how such treatments produce their therapeutic effects.

Advancements in treating tobacco use and nicotine addiction have been summarized in an evidence-based guideline, *Treating Tobacco Use and Dependence: A Clinical Practice Guideline*, published by the U.S. Public Health Service. Less intensive interventions, such as brief physician advice to quit smoking, could produce cessation rates of 5 to 10 percent per year. More intensive interventions, combining behavioral counseling and pharmacological treatment of nicotine addiction, can produce cessation rates of 20 to 25 percent per year.

Treating tobacco dependence is particularly important economically in that it can prevent a variety of costly chronic diseases, including heart disease, cancer, and chronic lung disease. It has been estimated that smoking cessation is more cost-effective than other commonly provided clinical preventive services, including screening for cervical, breast, and colon cancer, treatment of mild to moderate high blood pressure, and treatment of high cholesterol. Not surprisingly, *Healthy People 2010* calls for universal insurance coverage of evidence-based treatment for nicotine dependency.

Regulatory Efforts

Tobacco products are far less regulated in the United States than they are in many other developed countries. This level of regulation applies to the manufactured tobacco products; to the advertising, promotion, and sales of these products; and to the protection of nonsmokers from the involuntary exposure to ETS from the use of these products. Effective regulatory approaches can minimize the onset of smoking, particularly among young people, and may change tobacco use as an accepted social norm.

Advertising and Promotion

The report concludes that regulation of the sale and promotion of tobacco products is needed to protect young people from smoking initiation. Current regulation of advertising and promotion of tobacco products in this country is considerably less restrictive than in several other countries, notably Canada and New Zealand. In 1998, tobacco companies spent $6.7 billion to market their products–more than $18 million each day. Attempts to regulate tobacco marketing continue to take place in a markedly adversarial and litigious atmosphere.

Product Regulation

Warning labels on cigarette packages in the United States are weaker and less conspicuous than those of other countries, notably Canada and Australia. Federal law preempts, in part, states and localities from imposing other labeling regulations on cigarettes and smokeless tobacco.

Smokers receive very little information regarding chemical constituents when they purchase a tobacco product. Without information about toxic constituents in tobacco smoke, the use of terms such as "light" and "ultra light" on packaging and in advertising may be misleading to smokers. Because cigarettes with low tar and nicotine contents are not substantially less hazardous than higher-yield brands, consumers may be misled by the implied promise of reduced toxicity underlying the marketing of such brands. As with all other consumer products, adult users of tobacco should be fully informed of the products' ingredients and additives and any known toxicity when used as intended. Additionally, the manufactured tobacco product should be no more harmful than necessary given available technology.

Clean Indoor Air Regulation

Although population-based data show declining environmental tobacco smoke (ETS) exposure in the workplace over time, ETS exposure remains a common public health hazard that is entirely preventable. Most state and local laws for clean indoor air reduce but do not eliminate nonsmokers' exposure to ETS; smoking bans are the most effective method for reducing ETS exposure. Beyond eliminating ETS exposure among nonsmokers, smoking bans have additional benefits, including reduced smoking intensity and potential cost savings to employers. Optimal protection of nonsmokers and smokers requires a smoke-free environment.

Minors' Access to Tobacco

Despite the widespread support among the general public, policymakers, and the tobacco industry for restricting the access of minors to tobacco products, a high proportion of underage youth smokers across this country continue to be able to purchase their own

tobacco. Measures that have had some success in reducing minors' access include restricting distribution, regulating the mechanisms of sale, enforcing minimum age laws, and providing merchant education and training. Requiring licensure of tobacco retailers provides both a funding source for enforcement and an incentive to obey the law when revocation of the license is a provision of the law.

Litigation approaches

Private law initiative is a diffuse, uncentralized activity, and the sum of such efforts is unlikely to produce optimal results for a larger policy to reduce tobacco use. On the other hand, the actions of individuals are likely to be a valuable component in some larger context of strategies to make tobacco use less prevalent.

Economic Interventions

Research clearly shows that raising tobacco prices is good public health policy. Further, raising tobacco excise taxes is widely regarded as one of the most effective tobacco prevention and control strategies. Increasing the price of tobacco products will decrease the prevalence of tobacco use, particularly among adolescents and young adults. Nevertheless, the average price and excise tax levels on cigarettes in the United States is well below that of most industrialized nations.

Furthermore, the taxes on smokeless tobacco products are well below those on cigarettes in the U.S. Making optimal use of economic strategies in a comprehensive program poses special problems because of the complexity of government and private controls over tobacco economics and the need for a concerted, multilevel, political approach. *Healthy People 2010* calls for state and federal taxes to average $2.00 for both cigarettes and smokeless tobacco products by 2010.

Comprehensive Programs

The most important advance in comprehensive programs has been the emergence of statewide tobacco control efforts. Evidence shows that multifaceted, state-based tobacco control programs are effective in reducing tobacco use. Components of a multifaceted approach include:

(1) community interventions, which include diverse entities such as schools, health agencies, city and county governments, and civic, social, and recreation organizations (2) countermarketing, which includes using media advocacy, paid media, prohealth promotions, and other media strategies to change social norms regarding tobacco use (3)program policy and regulation, which addresses such issues as minors' access, tobacco pricing, advertising and promotion, clean indoor air, product regulation, and tobacco use cessation and (4) surveillance and evaluation, which includes monitoring tobacco industry promotional campaigns, evaluating the economic impact of ETS laws and policies, conducting surveys of public opinion on program interventions, and other activities to make ongoing refinements that lead to more effective prevention strategies. The synergy created by the interaction of various program components in a comprehensive approach is believed to be responsible for increased success in reducing tobacco use.

Global Efforts

The report addresses research on strategies to reduce tobacco use within our nation's social, legal, and cultural environment. Nevertheless, findings from this report may have broad utility in the planning of tobacco control efforts around the world. Globally, smoking-related deaths will rise to 10 million per year by 2030, and 7 million of these deaths will occur in developing countries. For the first time, the United States will collaborate with international organizations like the World Health Organization and with individual countries to help create a global partnership to stem the pandemic of tobacco-related death and disease. This report can serve as a blueprint with which the national and global public health communities can begin building capacity to combat the devestating health and economic effects of tobacco use.

Elimination of Health Disparities

The elimination of health disparities related to tobacco use poses a great national challenge. Cultural, ethnic, religious, and social differences are clearly important in understanding patterns of tobacco use. Reaching the national goal of eliminating health disparities related to tobacco use will require more research to develop effective interventions for various population groups.

For more information:

To obtain a copy of *Reducing Tobacco Use: A Report of the Surgeon General* full report or executive summary or for additional copies of this *At A Glance*, please call CDC's Office on Smoking and Health at (770) 488-5705 and press 3 to speak with an information specialist. Please note that the report, along with supporting documents, is available on-line at the Office on Smoking and Health Web site at www.cdc.gov/tobacco.

Background

What works?

It would be a boon if the answer were as easy to state as the question. Programs to reduce the use of tobacco have a long history in the United States and in other countries, and the accumulated experience has provided considerable empirical understanding of the prospects and pitfalls of such efforts. Rigorous answers to formal evaluation questions are difficult to obtain, however, in part because of the wide variety of influences that are brought to bear on the use of tobacco. Researchers have little control over many of these influences and are only beginning to learn how to measure some of them.

Nonetheless, a substantial body of literature exists on attempts to reduce the use of tobacco. This report provides an overview of the major modalities that have been studied and used intensively, and it attempts, where possible, to differentiate their techniques and outcomes. The report also attempts a more difficult task: to provide some qualitative observations about how these efforts interact. The report is thus a prologue to the development of a coherent, long-term policy that would permit these modalities to be used as effectively as possible.

This report of the Surgeon General was prepared by the Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, to report current information on the health effects of cigarette smoking and smokeless tobacco use. Previous reports have dealt with some of the issues included in this report, but a composite assessment of efforts to reduce tobacco use is a new topic for this series. However, the current report must acknowledge the considerable contributions of two prior monographs: *Growing Up Tobacco Free*, a report of the Institute of Medicine (Lynch and Bonnie 1994), and *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, an ongoing work of the Office of Health Promotion and Disease Prevention (USDHHS 1991).

Several concerns guided preparation of the report. First, it was clear that the primary countervailing influence against reducing tobacco use is the effort of the tobacco industry to promote the use of tobacco products. Although this report was not conceived as a documentation of such industry efforts, repeated reference to them is necessary to underscore the difficulties both in achieving desired outcomes and in evaluating the effectiveness of efforts to reduce the use of the industry's products. Second, the report has attempted to present the wide variety of techniques and methods used for tobacco control, but the disparate methods make comparisons difficult. The result is more a menu than a cookbook—a set of activities, as outlined in Chapter 7, whose combination depends on specific circumstances and the context in which they are undertaken. Third, a result of this methodological diversity is that rigorous evaluation of the ways in which tobacco reduction efforts interact remains part of the unfinished research agenda. Although interaction of interventive efforts is noted several places in the report (see, for example, the discussion of the interaction of school education with community-based programs in Chapter 3), such demonstration of synergy has been elusive.

Finally, during the report's preparation, a cascade of legal and legislative events substantially changed the landscape where the diverse efforts to reduce tobacco use take place. Several legal rulings, still under adjudication, and the Master Settlement Agreement between states and the tobacco industry to recover costs of government programs have altered prospects for reducing tobacco use through large-scale social maneuvers. Many of these issues are still unresolved, and they are likely to influence activities in the coming years.

Issues in Reducing Tobacco Use

Two themes have permeated the history of tobacco use in the United States. First, and most obviously, tobacco is an extraordinary economic fuel, and its powerful economic impact comes into direct conflict with its vast social costs. Second, antitobacco activity has a continuous history characterized by waxing and waning and by a changing mix of motivations and strategies. These two themes are inextricably linked, and their interaction provides a backdrop for current efforts to reduce tobacco use.

Such efforts take place in a complicated context. Chronic diseases have largely replaced infectious processes as the leading causes of death during the 20th century (Rothenberg and Koplan 1990). But this replacement has occurred during a period of remarkable gains in life expectancy. Mortality is now less than half of what it was in 1900. The single most important risk associated with the leading chronic diseases is cigarette smoking; the evidence for that statement fills volumes of Surgeon General's reports on smoking and health, and these volumes are merely summaries of a massive literature. Since the first of these reports in 1964, the prevalence of smoking has declined by nearly half, and it is clear that the declining use of tobacco has contributed to the observed decline in mortality. But the decline has been a slower decline than would be warranted by awareness of the well-publicized public health threat that smoking poses. The forces that have tried to accelerate the decline may be thought of collectively as "interventions," although the term, in a more narrow sense, is often reserved for circumscribed, planned, and measurable activities. Many of the maneuvers described in this report do not meet the narrower definition, but all share the common characteristic of being directed toward a reduction in tobacco use.

The result is a considerable challenge for evaluation. In an environment in which multiple interventions are in play, the ability to attribute an individual positive outcome (e.g., smoking cessation, prevention of smoking uptake) to one of them is virtually impossible. Although the epidemiologic methods exist to evaluate attribution in the aggregate, data are rarely available to make such judgments. The challenge of evaluating these separate efforts and strategies results from their disparate nature and the type of metric that may be appropriate to their evaluation.

Management of nicotine addiction (Chapter 4), for example, is usually studied by using standard epidemiologic study design—often a prospective comparison of a study group and a control group—and the effect is measured by some form of the relative or attributable risk statistic. Educational strategies (Chapter 3), like other behavioral studies, may use similar statistics but usually invoke a different set of confounding factors to be considered; sorting out the relative influence of such factors often requires complex multivariate procedures. Regulatory efforts (Chapter 5) are frequently evaluated after the effect (with a pre- and post-type of study design) or are evaluated according to ecological correlations with changes in epidemiologic trends. Economic measures (Chapter 6) depend for their evaluation on econometric information—that is, on administrative data sets and survey results that are subjected to correlation and trend analysis. Finally, comprehensive program strategies are often evaluated using surveillance data systems, trend analyses, and case studies.

In each instance, some form of evaluation is possible, but the ability to connect the intervention to the outcome differs greatly among these efforts, as does the ability to estimate impact. Theoretically, it might be possible to associate each effort with some presumed number of persons who start smoking or some number who quit, but to do so would usually require numerous assertions and assumptions. Without a common metric, the various types of efforts to reduce tobacco use are difficult to compare quantitatively, and perhaps a more qualitative approach should be used. One approach would be to consider the potential span of impact (the proportion of the population, or population sectors) that the particular effort can exercise in the context of a qualitative estimate of its potential impact. For example, clinical methods to manage nicotine addiction may now be thought to have relatively high impact, but a relative small span. Economic measures can be judged to have both high impact and large span. Each of the interventions has its appropriate place and context: they line up side by side and not in relative order. Their use is predicated on the particular context in which they are to operate. Because they all face the same counterinfluence of the industry's tobacco promotion, a reasonable case can be made that the large-scale strategies (economic and regulatory) have the greatest direct impact on that barrier. But the

context necessary for those large-scale efforts to work depends on public attitudes and social norms that must be influenced by other means.

In the 1990s, it became increasingly apparent that a public health success in reducing tobacco use requires activity on all fronts. A comprehensive approach—one that optimizes synergy from a mix of strategies—has emerged as the guiding principle for future efforts to reduce tobacco use. Such an approach makes moot the issue of a hierarchy of interventions, since a comprehensive approach presupposes an interdependence of the available strategies. A coordinated, cohesive infrastructure makes intuitive sense, since it permits a modular approach to the interventions themselves, but has been challenged on analytic grounds. In such a framework, attribution of success to particular program elements is difficult, and there is no experimental evidence (nor is there likely to be) that an approach that is comprehensive is superior to one that is not. Nonetheless, the 20th century's difficult experience with tobacco control (as described in Chapter 2) and the previous decade's success in changing social norms and generating assets (as discussed in Chapter 7) lend empirical credibility to the comprehensive approach.

Finally, a separate theme—not a major focus of the current report because two other recent, important publications have emphasized this issue—is the elimination of health disparities related to tobacco use, which poses a great challenge to this nation. The 1998 Surgeon General's report, *Tobacco Use Among U.S. Racial/Ethnic Minority Groups* (USDHHS 1998), was the first to address the diverse tobacco control needs of the four major U.S. racial/ethnic minority groups—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics. *Healthy People 2010* has two overarching goals: increase quality and years of healthy life and eliminate health disparities among different segments of the U.S. population. Evidence reviewed in these two publications highlights the significant disparities in health that exist in the United States. These publications also highlight the critical need for a greater focus on this issue, both in research and in public health action.

Findings

Each of the approaches described in this report shows evidence of effectiveness. In some instances, the synergism that might be expected through interaction among these various efforts has been documented, and the implications for future tobacco control and prevention activities are noted.

Historical Review (Chapter 2)

The forces that have shaped the movement to reduce tobacco use over the past 100 years are complex and intertwined. In the early years (1880–1920), antitobacco activity—some of it quite successful—was motivated by moral and hygienic principles. After important medical and epidemiologic observations of the midcentury linked smoking to lung cancer and other diseases, and after the subsequent appearance of the 1964 report of the advisory committee to the Surgeon General on smoking and health (U.S. Department of Health, Education, and Welfare 1964), the movement to reduce tobacco use was fueled by knowledge of the health risks that tobacco use poses and by reaction against the continued promotion of tobacco in the face of such known risks. Despite overwhelming evidence of adverse health consequences of smoking, the stubborn norm of smoking in the United States has receded slowly, in part because of such continued promotion that works synergistically with tobacco addiction. Although strategies have varied, health advocates have focused in recent years on the prevention of harm to nonsmokers and on the concept of smoking as a pediatric disease, with the consequent need for protecting young persons from forces influencing them to smoke.

Educational Strategies (Chapter 3)

The design of educational programs for tobacco use prevention and the methods used to evaluate them have become increasingly refined over the past two decades. Early studies tended to be confined to the school context, to have short duration, and to be of low intensity. Studies tended to focus on a single modality and to ignore the larger context in which prevention

takes place. The reported size, scope, and duration of program effects have become larger in recent reports. In particular, several large programs have attempted a multifaceted approach that incorporates other than school-based modalities. Improvements in evaluation designs have increased confidence in the validity of these reports. The pattern of consistency across this group of large studies also provides assurance that these effects can be achieved in a variety of circumstances when programs include the critical multiple elements that have been defined by this research literature.

To summarize the major findings, school-based social influences programs have significant and substantial short-term impacts on smoking behavior. Those programs with more frequent educational contacts during the critical years for smoking adoption are more likely to be effective, as are programs that address a broad range of educational needs. These effects have been demonstrated in a range of implementation models and student populations. The smoking prevention effects of strong school programs can be extended through the end of high school or longer when combined with relatively intensive efforts directed through other powerful channels, such as strategies that vigorously engage the influences of parents, the mass media, and other community resources. These conclusions have been codified in national guidelines for school programs to prevent tobacco use.

Thus, an extensive body of research findings document the most effective educational programs for preventing tobacco use. This research has produced a wide array of curricula, protocols, and recommendations that have been codified into national guidelines for schools. Implementing guidelines could postpone or prevent smoking onset in 20 to 40 percent of U.S. adolescents. Unfortunately, existing data suggest that evidence-based curricula and national guidelines have not been widely adopted. By one set of criteria, less than 5 percent of schools nationwide are implementing the major components of CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction* (CDC 1994). Almost two-thirds of schools (62.8 percent) had smoke-free building policies in 1994, but significantly fewer (36.5 percent) reported such policies that included the entire school environment.

Schools, however, should not bear the sole responsibility for implementing educational strategies to prevent tobacco use. Research findings, as noted, indicate that school-based programs are more effective when combined with mass media programs and with community-based efforts involving parents and other community resources. In addition, CDC's school health guidelines and numerous *Healthy People 2010* objectives recognize the critical role of implementing tobacco-free policies involving faculty, staff, and students and relating to all school facilities, property, vehicles, and events. Although significant progress is still required, the current evaluation base provides clear direction for the amalgamation of school-based programs with other modalities for reducing tobacco use.

Management of Nicotine Addiction (Chapter 4)

The management of nicotine addiction is a complex field that continues to broaden its understanding of the determinants of smoking cessation. Current literature suggests that several modalities are effective in helping smokers quit. Although the overall effect of such intervention is modest if measured by each attempt to quit, the process of overcoming addiction is a cyclic one, and many who wish to quit are eventually able to do so. The available approaches to management of addiction differ in their results.

Self-Help Manuals and Minimal Clinical Interventions

Although self-help manuals have had only modest and inconsistent success at helping smokers quit, manuals can be easily distributed to the vast population of smokers who try to quit on their own each year. Adjuvant behavioral interventions, particularly proactive telephone counseling, may significantly increase the effect of self-help materials. Process measures are not routinely incorporated into self-help investigations, but the available process data suggest that persons who not only have a self-help manual but also perform the exercises recommended in the manual are more likely to quit smoking than are persons who try to quit smoking without them.

Substantial evidence suggests that minimal clinical interventions (e.g., a health care provider's repeated advice to quit) foster smoking cessation and that the more multifactorial or intensive interventions produce the best outcomes. These findings highlight the importance of cessation assistance from clinicians, who have access to more than 70 percent of smokers each year. Moreover, minimal clinical interventions have been found to be effective in increasing smokers' motivation to quit and are cost-effective (see "Cost-Effectiveness" in Chapter 4). However, research has not fully clarified the specific elements of minimal interventions that are most important to clinical success or the specific changes they produce in smokers that lead to abstinence.

Intensive Clinical Interventions

Intensive programs—more formally, systematic services to help people quit smoking—serve an important function in the nation's efforts to reduce smoking, despite the resources the programs demand and the relatively small population of smokers who use them. Such programs may be particularly useful in treating those smokers who find it most difficult to quit. Because intensive smoking cessation programs differ in structure and content, evaluation is often hampered by variation in methodology and by a lack of research addressing specific treatment techniques. Because few studies have chosen to isolate single treatments, assessment of the effectiveness of specific approaches is difficult. Nonetheless, skills training, rapid smoking, and both intratreatment and extratreatment social support have all been associated with successful smoking cessation. When such treatments are shown to be effective, they are usually part of a multifactorial intervention. Little clear evidence has implicated particular psychological, behavioral, or cognitive mechanisms as the agents of change. The specific impact of intensive interventions may be masked by the efficacy of several multicomponent programs, some of which have achieved cessation proportions of 30 to 50 percent. Thus, in their positive effect on smoking cessation and long-term abstinence rates, intensive interventions seem little different from other forms of counseling or psychotherapy. With intensive interventions, as with counseling, it is difficult to attribute the efficacy to specific characteristics of the interventions or to specific change mechanisms.

Pharmacologic Interventions

Abundant evidence confirms that nicotine gum and the nicotine patch are effective aids to smoking cessation. The efficacy of nicotine gum may depend on the amount of behavioral counseling with which it is paired. The 4-mg dose (rather than the 2-mg dose) may be the better pharmacologic treatment for heavy smokers or for those highly dependent on nicotine. The nicotine patch appears to exert an effect independent of behavioral support, but absolute abstinence rates increase as more counseling is added to patch therapy. Nicotine inhalers and nicotine nasal spray are effective aids for smoking cessation, although their mechanisms of action are not entirely clear. All nicotine replacement therapies produce side effects, but these are rarely so severe that patients must discontinue use. Nicotine nasal spray appears to have greater potential for inappropriate use than other nicotine replacement therapies. Nicotine replacement therapies, especially the gum and the patch, have been shown to delay but not prevent weight gain following smoking cessation. All nicotine replacement therapies are thought to work in part by reducing withdrawal severity. The available evidence suggests that they do ameliorate some elements of withdrawal, but the relationship between withdrawal suppression and clinical outcome is inconsistent.

Bupropion is the first nonnicotine pharmacotherapy for smoking cessation to be studied in large-scale clinical trials. Results suggest that bupropion is an effective aid to smoking cessation. In addition, bupropion has been demonstrated to be safe when used jointly with nicotine replacement therapy. In the only direct comparison with a nicotine replacement product, bupropion achieved quit rates about double those achieved with the nicotine patch. Bupropion appears to delay but not prevent postcessation weight gain. The available literature contains inconsistent evidence regarding bupropion-mediated withdrawal relief. Bupropion does not appear to work by reducing postcessation symptoms of depression, but its mechanism of action in smoking cessation remains unknown.

Evidence has suggested that clonidine is capable of improving smoking cessation rates. Clonidine is hypothesized to work by alleviating withdrawal symptoms. Although clonidine may reduce craving for cigarettes after cessation, it does not consistently ameliorate other withdrawal symptoms, and its effects with weight gain are unknown. Unpleasant side effects are common with clonidine use.

Antidepressants and anxiolytics are potentially useful agents for smoking cessation. At present only nortriptylene appears to have consistent empirical evidence of smoking cessation efficacy. However, tricyclic antidepressants produce a number of side effects, including sedation and various anticholinergic effects, such as dry mouth.

In summary, research on methods to treat nicotine addiction has documented the efficacy of a wide array of strategies. The broad implementation of these effective treatment methods could produce a more rapid and probably larger short-term impact on tobacco-related health statistics than any other component of a comprehensive tobacco control effort. It has been estimated that smoking cessation is more cost-effective than other commonly provided clinical preventive services, including Pap tests, mammography, colon cancer screening, treatment of mild to moderate hypertension, and treatment of high levels of serum cholesterol.

Contemporaneously with the appearance of this report, research advances in managing nicotine addiction have been summarized in evidence-based clinical practice guidelines by the Centers for Disease Control and Prevention (CDC). That document confirms that less intensive interventions, such as brief physician advice to quit smoking, could produce cessation rates of 5 to 10 percent per year. More intensive interventions, combining behavioral counseling and pharmacologic treatment of nicotine addiction, can produce 20 to 25 percent quit rates at one year. Thus, the universal provision of even less intensive interventions to smokers at all clinical encounters could each year help millions of U.S. smokers quit (Fiore et al. 2000).

Progress has been made in recent years in disseminating clinical practice guidelines on smoking cessation. *Healthy People 2010* Objective 27-8 calls for universal insurance coverage of evidence-based treatment for nicotine dependency by both public and private payers. Similarly, CDC's *Best Practices for Comprehensive Tobacco Control Programs* advises states that tobacco-use treatment initiatives should include

- Establishing population-based counseling and treatment programs, such as cessation help lines.
- Making the system changes recommended by the CDC-sponsored cessation guidelines.
- Covering treatment for tobacco use under both public and private insurance.
- Eliminating cost barriers to treatment for underserved populations, particularly the uninsured (CDC 1999, p. 24).

Regulatory Efforts (Chapter 5)

Advertising and Promotion

Attempts to regulate advertising and promotion of tobacco products were initiated in the United States almost immediately after the appearance of the 1964 report to the Surgeon General on the health consequences of smoking (USDHEW 1964). Underlying these attempts is the hypothesis that advertising and promotion recruit new smokers and retain current ones, thereby perpetuating a great risk to public health. The tobacco industry asserts that the purpose of marketing is to maintain brand loyalty. Considerable evidence has accumulated showing that advertising and promotion are perhaps the main motivators for adopting and maintaining tobacco use. Attempts to regulate tobacco marketing continue to take place in a markedly adversarial and litigious atmosphere.

The initial regulatory action, promulgated in 1965, provided for a general health warning on cigarette packages but effectively preempted any further federal, state, or local requirements for health messages. In 1969, a successful court action invoked the Fairness Doctrine (not previously applied to advertising) to require broadcast media to air antitobacco advertising to counter the paid tobacco advertising then running on television and radio. Indirect evidence suggests that such counteradvertising had considerable impact on the public's perception of smoking. Not surprisingly, the tobacco industry supported new legislation (adopted in 1971) prohibiting the advertising of tobacco products on broadcast media, because such legislation also removed the no-cost broadcasting of antitobacco advertising. A decade later, a Federal Trade Commission (FTC) staff report asserted that the dominant themes of remaining (nonbroadcast) cigarette advertising associated smoking with "youthful vigor, good health, good looks and personal, social and professional acceptance and success" (Myers et al. 1981, p. 2-13). A nonpublic version of the report detailed some of the alleged marketing strategy employed by the industry; the industry denied the allegation that the source material for the report represented industry policy. Nonetheless, some of these concerns led to the enactment of the Comprehensive Smoking Education Act of 1984 (Public Law 98-474), which required a set of four rotating warnings on cigarette packages. The law did not, however, adopt other FTC recommendations that product packages should bear information about associated risks of addiction and miscarriage, as well as information on toxic components of cigarettes. In fact, many FTC-recommended requirements for packaging information that have been enacted in other industrialized nations have not been enacted in the United States.

The role of advertising is perhaps best epitomized by R.J. Reynolds Tobacco Company's Camel brand campaign (initiated in 1988) using the cartoon character "Joe Camel." Considerable research has demonstrated the appeal of this character to young people and the influence that the advertising campaign has had on minors' understanding of tobacco use and on their decision to smoke. In 1997, the FTC brought a complaint asserting that by inducing minors to smoke, R.J. Reynolds' advertising practices violated the Federal Trade Commission Act (Public Law 96-252). The tobacco company subsequently agreed to cease using the Joe Camel campaign. Although the FTC's act grants no private right of enforcement, a private

lawsuit in California resulted in a settlement whereby the tobacco company agreed to cease its Joe Camel campaign; notably, the Supreme Court of California rejected R.J. Reynolds' argument that the Comprehensive Smoking Education Act of 1984 preempted the suit's attempt to further regulate tobacco advertising.

Product Regulation

Current tobacco product regulation requires that cigarette advertising disclose levels of "tar" (an all-purpose term for particulate-phase constituents of tobacco smoke, many of which are carcinogenic or otherwise toxic) and nicotine (the psychoactive drug in tobacco products that causes addiction) in the smoke of manufactured cigarettes and that warning labels appear on packages and on some (but not all) advertising for manufactured cigarettes and smokeless tobacco. The current federal laws preempt, in part, states and localities from imposing other labeling regulations on cigarettes and smokeless tobacco. Federal law (the Comprehensive Smokeless Tobacco Health Education Act of 1986 and the Comprehensive Smoking Education Act of 1984) requires cigarette and smokeless tobacco product manufacturers to submit a list of additives to the Secretary of Health and Human Services; attorneys for the manufacturers released such lists in 1994 to the general public. Smokeless tobacco manufacturers are required to report the total nicotine content of their products, but these data may not be released to the public. Tobacco products are explicitly protected from regulation in various federal consumer safety laws. No federal public health laws or regulations apply to cigars, pipe tobaccos, or fine-cut cigarette tobaccos (for "roll-your-own" cigarettes).

Although much effort has been devoted to considering the need for regulating nicotine delivery, tar content, and the use of additives, until recently no regulation had directly broached the issue of whether tobacco should be subject to federal regulation as an addictive product. Responding in part to several petitions filed by the Coalition on Smoking OR Health in 1988 and 1992, the FDA began serious consideration of the need for product regulation. Motivated by the notion that the cigarette is a nicotine delivery system, by allegations of product manipulation of nicotine levels, and by the concept that smoking is a pediatric disease and that young people are especially susceptible to cigarette advertising and promotion, in August 1995 the FDA issued in the *Federal Register* (1) a proposed rule of regulations restricting the sale and distribution of cigarettes and smokeless tobacco products to protect children and adolescents and (2) an analysis of the FDA's jurisdiction over cigarettes and smokeless tobacco. The final regulations published by the FDA on August 28, 1996, differed only slightly from the proposed regulation. The announcement prompted immediate legal action on the part of the tobacco industry, advertising interests, and the convenience store industry, which challenged the FDA's jurisdiction over tobacco products. In April 1997, a federal district court upheld the FDA's jurisdiction over tobacco products, but held that it lacked authority under the statutory provision relied on to regulate tobacco product advertising.

Although many of the FDA's regulations on tobacco sales and distribution were incorporated, to some extent, in the June 20, 1997, proposed settlement of lawsuits between 41 state attorneys general and the tobacco industry, the settlement presupposed congressional legislation that would uphold the FDA's asserted jurisdiction. After considerable congressional negotiation, no such legislation emerged. In August 1998, a three-judge panel of the United States Court of Appeals for the Fourth Circuit held that the FDA lacked jurisdiction to regulate tobacco products. In November 1998, the full court of appeals rejected the government's request for rehearing by the entire court. On March 21, 2000, in a 5 to 4 decision, the United States Supreme Court affirmed the decision of the United States Court of Appeals for the Fourth Circuit and held that the FDA lacks jurisdiction under the Federal Food, Drug, and Cosmetic Act to regulate tobacco products as customarily marketed. As a result of this decision, the FDA's August 1996 assertion of jurisdiction over cigarettes and smokeless tobacco and regulations restricting the sale and distribution of cigarettes and smokeless tobacco to protect children and adolescents (principally codified at 21 Code of Federal Regulations Part 897) are invalid.

Clean Indoor Air Regulation

Unlike the regulation of tobacco products per se and of their advertising and promotion, regulation of exposure to ETS has encountered less resistance. This course is probably the result of (1) long-standing grassroots efforts to diminish exposure to ambient tobacco smoke and (2) consistent epidemiologic evidence of adverse health effects of ETS. Since 1971, a series of rules, regulations, and laws have created smoke-free environments in an increasing number of settings: government offices, public places, eating establishments, worksites, military establishments, and domestic airline flights. As of December 31, 1999, smoking was restricted in public places in 45 states and the District of Columbia. Currently, some 820 local

ordinances, encompassing a variety of enforcement mechanisms, are in place.

The effectiveness of clean indoor air restrictions is under intensive study. Most studies have concluded that even among smokers, support for smoking restrictions and smoke-free environments is high. Research has also verified that the institution of smoke-free workplaces effectively reduces nonsmokers' exposure to ETS. Although smoke-free environments have not reduced smoking prevalence in most studies, such environments have been shown to decrease daily tobacco consumption among smokers and to increase smoking cessation.

Minors' Access to Tobacco

There is widespread approval for restricting the access of minors to tobacco products. Recent research, however, has demonstrated that a substantial proportion of teenagers who smoke purchase their own tobacco, and the proportion varies with age, social class, amount smoked, and factors related to local availability. In addition, research has shown that most minors can easily purchase tobacco from a variety of retail outlets. It has been suggested that a reduction in commercial availability may result in a reduced prevalence of tobacco use among minors.

Several approaches have been taken to limiting minors' access to tobacco. All states prohibit sale or distribution of tobacco to minors. More than two-thirds of states regulate the means of sale through restrictions on minors' use of vending machines, but many of these restrictions are weak, and only two states have total bans on vending machines. Restrictions on vending machines are a subclass of the larger category of regulation of self-service cigarette sales; in general, such regulation requires that cigarettes be obtained from a salesperson and not be directly accessible to customers. Such policies can reduce shoplifting as well, an important source of cigarettes for some minors.

Regulations directed at the seller include the specification of a minimum age for sale (18, in all but two states and Puerto Rico), a minimum age for the seller, and the prominent in-store announcement of such policy. Providing merchant education and training is an important component of comprehensive minors' access programs. Penalties for sales to minors vary considerably; in general, civil penalties have been found to be more effective than criminal ones. Requiring licensure of tobacco retailers has been found to provide a funding source for compliance checks and to serve as an incentive to obey the law when revocation of the license is a provision of the law. Applying penalties to business owners, instead of to clerks only, is considered essential to preventing sales to minors. Tobacco retail outlets and the tobacco industry have vigorously opposed this policy. An increasing number of states and local jurisdictions are imposing sanctions against minors who purchase, possess, or use tobacco products. Sanctions against both buyers and sellers are enforced by a variety of agencies and mechanisms. Because regulations in general may be more effective if generated and enforced at the local level, considerable energy is devoted to the issue of opposing or repealing preemption of local authority by states. Public health analyses have resulted in strong recommendations that state laws not preempt local action to curb minors' access to tobacco.

Litigation Approaches

Private litigation shifts enforcement of public health remedies from the enterprise or the government to the private individual—typically, victims or their surrogates. In the tort system, the coalescence of instances in which injurers are forced to compensate the injured can create a force that generates preventive effects. Though relatively inefficient as a system for compensating specific classes of injuries, the tort system is justified by its generation of preventive actions and by its flexibility. Tobacco represents an atypical pattern of litigation and product modification, because private law remedies have not yet succeeded in institutionalizing recovery for tobacco injuries or have not yet generated significant preventive effects. In the case of tobacco, regulation has been the predominant control, and such regulation has been distinctive in relying primarily on notification requirements rather than safety requirements.

Private litigation against tobacco has occurred in several distinct waves. The first wave was launched in 1954 and typically used one or both of two legal theories: negligence and implied warranty. Courts proved unreceptive to both these arguments, and this approach had receded by the mid-1970s. In many of these and subsequent cases, legal devices and exhaustion of plaintiff resources figured prominently in the defendants' strategy. A second wave began in 1983 and ended in 1992. In these cases, the legal theory shifted from warranty to strict liability. The tobacco industry based its defense on smokers' awareness of risks and so-called freedom of choice. For example, plaintiffs argued that the addictive nature of nicotine limited free choice; defense counsel rebutted by pointing to the large number of former smokers who successfully quit. Taking freedom-of-choice defense even

further, counsel argued that the claimant's lifestyle was overly risky by choice or was in some way immoral. The case that symbolized the second-wave litigation was that filed by Rose Cipollone, a dying smoker, in 1983. The Supreme Court accepted the tobacco industry's defense that federal law requiring warning labels on product packages had preempted claims under state law that imposed liability for failure to warn. The United States Supreme Court left open several other approaches, but the likelihood of recovery seemed small, and counsel for the Cipollone estate withdrew.

In the third wave, begun soon after the Cipollone decision and still ongoing, diverse legal arguments have been invoked. This third wave of litigation differs from its predecessors by enlarging the field of plaintiffs, focusing on a range of legal issues, using the class action device, and making greater attempts to use private law for public policy purposes. These new claims have been based on theories of intentional misrepresentation, concealment, and failure to disclose, and such arguments have been joined to a new emphasis on addiction. For example, in one case that ended as a mistrial, plaintiffs were barred from presenting evidence that the tobacco companies may have manipulated nicotine levels. The class action device has figured prominently in these new cases, which have included claims of smokers as well as claims of those who asserted that they have been injured by ETS. Arguably the most notable series of third-wave claims brought against tobacco companies is the proposed 1997 settlement of suits brought by 41 state attorneys general attempting to recover the states' Medicaid expenditures for treating tobacco-related illnesses. In the absence of congressional legislation needed to give that settlement the force of law, four states made independent settlements with the tobacco industry. Notably, each state obtained a concession guaranteeing that it would benefit from any more favorable agreement that another state might later obtain from the tobacco industry. Subsequently, a multistate Master Settlement Agreement was negotiated in November 1998 covering the remaining 46 states, the District of Columbia, and five commonwealths and territories. Another notable recent development is the filing of large claims by other third-party payers, such as large health care plans.

Perhaps in partial response, the level of litigation initiated by the tobacco industry itself has increased in recent years and has included a number of well-publicized cases, including a threatened suit against the media to prevent airing of a program that accused a tobacco company of manipulating nicotine levels. The company was successful in making the network withdraw the program, even though similar information was later made public in other contexts. Although the industry continues aggressive legal pursuit of its interests on a number of fronts, litigation against the industry has had undoubted impact on tobacco regulation and is likely to continue to play a key role in efforts to reduce tobacco use.

Overview and Implications

Tobacco products are far less regulated in the United States than they are in many other developed countries. This level of regulation applies to the manufactured tobacco product; to the advertising, promotion, and sales of these products; and to the protection of nonsmokers from the involuntary exposure to ETS from the use of these products. As with all other consumer products, adult users of tobacco should be fully informed of the products' ingredients and additives and of any known toxicity when used as intended. Additionally, as with other consumer products, the manufactured tobacco product should be no more harmful than necessary given available technology. The sale, distribution, and promotion of tobacco products need to be sufficiently regulated to protect underage youth from influences to take up smoking. Finally, involuntary exposure to ETS remains a common public health hazard that is entirely preventable by appropriate regulatory policies.

Such are the basic, reasonable regulatory issues related to tobacco products. Yet these issues remain unresolved as the new millennium begins. When consumers purchase a tobacco product, they receive little information regarding the ingredients, additives, or chemical composition in the product. Although public knowledge about the potential toxicity of most of these constituents is negligible, findings in this report conclude that the warning labels on cigarette packages in this country are weaker and less conspicuous than in other countries. Further, the popularity of "low tar and nicotine" brands of cigarettes has shown that consumers may be misled by another, carefully crafted kind of information—that is, by the implied promise of reduced toxicity underlying the marketing of these products.

Current regulation of the advertising and promotion of tobacco products in this country is considerably less restrictive than in several other countries, notably Canada and New Zealand. The review of current case law in this report supports the contention that greater restrictions of tobacco product advertising and promotion could be legally justified. In fact, the report concludes that regulation of the sale and promotion of tobacco products is needed to protect young people from smoking initiation.

ETS contains more than 4,000 chemicals; of these, at least 43 are known carcinogens (Environmental Protection Agency 1992). Exposure to ETS has serious health effects (USDHHS 2000b). Despite this documented risk, research has demonstrated that more than 88 percent of nonsmokers in this country aged 4 years and older had detectable levels of serum cotinine, a marker for exposure to ETS (Pirkle et al. 1996). The research reviewed in this report indicates that smoking bans are the most effective method for reducing ETS exposure. Four *Healthy People 2010* objectives address this issue and seek optimal protection of nonsmokers through policies, regulations, and laws requiring smoke-free environments in all schools, worksites, and public places.

Despite the widespread support among the general public, policymakers, and the tobacco industry for restricting the access of minors to tobacco products, a high proportion of underage youth smokers across this country continue to be able to purchase their own tobacco. National efforts by the Substance Abuse and Mental Health Services Administration to increase the enforcement of state laws to comply with the Synar Amendment and by the FDA to implement the access restrictions defined in their 1996 rule have reduced the percentage of retailers in many states who sell to minors. Unfortunately, nine states failed to attain their Synar Amendment targets in 1999. Additionally, the March 2000 Supreme Court ruling that the FDA lacks jurisdiction to regulate tobacco products has suspended all enforcement of the agency's 1996 regulations. Although several states have increased emphasis on this issue as part of their state-funded program efforts, the loss of the FDA's program removes a major infrastructure in support of these state efforts. The current regulatory environment poses considerable challenges for the interweaving of regulation into a comprehensive, multicomponent approach to tobacco use control and prevention.

Economic Approaches (Chapter 6)

The argument for using economic policy for reducing tobacco use requires considerable technical and analytic understanding of economic theory and data. Because experiments and controlled trials—in the usual sense—are not available to the economist, judgment and forecasting depend on the results of complex analysis of administrative and survey data. Such analyses have led to a number of conclusions regarding the importance of the tobacco industry in the U.S. economy and regarding the role of policies that might affect the supply of tobacco, affect the demand for tobacco, and use different forms of taxation as a possible mechanism for reducing tobacco use.

Supply

The tobacco support program has successfully limited the supply of tobacco and raised the price of tobacco and tobacco products. However, the principal beneficiaries of this program are not only the farmers whose income is supported but also the owners of the tobacco allotments. If policies were initiated to ameliorate some short-run effects, the tobacco support program could be removed without imposing substantial losses for many tobacco farmers. Eliminating the tobacco support program would lead to a small reduction in the prices of cigarettes and other tobacco products, which would lead to slight increases in the use of these products. However, because the support program has created a strong political constituency that has successfully impeded stronger legislation to reduce tobacco use, removing the support program could make it easier to enact stronger policies that would more than offset the impact that the resulting small reductions in price would have on demand.

Throughout the 1980s and 1990s, competition within the tobacco industry appeared to have decreased as a result of the favorable deregulatory business climate and an apparent increase in collusive behavior. This reduction in competition, coupled with the addictive nature of cigarette smoking, has magnified the impact that higher cigarette taxes and stronger smoking reduction policies would have on demand.

The recent expansion of U.S. trade in tobacco and tobacco products through multinational agreements, together with the U.S. threat of retaliatory trade sanctions were other countries to impede this expansion, is nearly certain to have increased the use of tobacco products worldwide. Such an increase would result in a consequent global rise in morbidity and mortality related to cigarette smoking and other tobacco use. These international trade policy efforts conflict with current domestic policies (and the support of comparable international efforts) that aim to reduce the use of tobacco products because of their harmful effects on health.

Industry Importance

Although employment in the tobacco industry is substantial, the industry greatly overstates the importance of tobacco to the U.S. economy. Indeed, most regions would likely benefit—for example, through

redistribution of spending and changes in types of job—from the elimination of revenues derived from tobacco products. Moreover, as the economies of tobacco-growing regions have become more diversified, the economic importance of tobacco in these areas has fallen. Higher tobacco taxes and stronger prevention policies could be joined to other efforts to further ease the transition from tobacco in major tobacco-producing regions. Finally, trading lives for jobs is an ill-considered strategy, particularly with the availability of stronger policies for reducing tobacco use.

Demand

Increases in the price of cigarettes will lead to reductions in both smoking prevalence and cigarette consumption among smokers; relatively large reductions are likely to occur among adolescents and young adults. Limited research indicates that increases in smokeless tobacco prices will similarly reduce the use of these products. More research is needed to clarify the impact of cigarette and other tobacco prices on the use of these products in specific sociodemographic groups, particularly adolescents and young adults. Additional research also is needed to address the potential substitution among cigarettes and other tobacco products as their relative prices change.

Taxation

After the effects of inflation are accounted for, federal and average state excise taxes on cigarettes are well below their past levels. Similarly, average cigarette excise taxes in the United States are well below those imposed in most other industrialized countries. Moreover, U.S. taxes on smokeless tobacco products are well below cigarette taxes. Studies of the economic costs of smoking report a wide range of estimates for the optimal tax on cigarettes. However, when recent estimates of the costs of ETS (including the long-term costs of fetal and perinatal exposure to ETS) are considered, and when the premature death of smokers is not considered an economic benefit, a tax that would generate sufficient revenues to cover the external costs of smoking is almost certainly well above current cigarette taxes. The health benefits of higher cigarette taxes are substantial. By reducing smoking, particularly among youth and young adults, past tax increases have significantly reduced smoking-related morbidity and mortality. Further increases in taxes, indexed to account for the effects of inflation, would lead to substantial long-run improvements in health.

The revenue potential of higher cigarette and other tobacco taxes—obviously not in itself a goal—is considerable; significant increases in these taxes would lead to sizable increases in revenues for many years. However, because of the greater price responsiveness of adolescents and young adults and the addictive nature of tobacco use, the long-run increase in revenues is likely to be less than the short-run gain. Nevertheless, current federal and most state tobacco taxes are well below their long-run revenue-maximizing levels.

In short, the research reviewed in this report supports the position that raising tobacco prices is good public health policy. Further, raising tobacco excise taxes is widely regarded as one of the most effective tobacco prevention and control strategies. Research indicates that increasing the price of tobacco products would decrease the prevalence of tobacco use, particularly among minors and young adults. As noted, however, this report finds that both the average price of cigarettes and the average cigarette excise tax in this country are well below those in most other industrialized countries and that the taxes on smokeless tobacco products are well below those on cigarettes. Making optimal use of economic strategies in a comprehensive program poses special problems because of the complexity of government and private controls over tobacco economics and the need for a concerted, multilevel, political approach.

Comprehensive Programs (Chapter 7)

Community-based interventions were originally developed as research projects that tested the efficacy of a communitywide approach to risk reduction. A number of national and international efforts to control cardiovascular disease (in the United States, notably the Minnesota, Stanford, and Pawtucket studies) used controlled designs. The results from these and other studies were largely disappointing, particularly regarding prevention and control of tobacco use. Other large-scale research efforts, such as the Community Intervention Trial (COMMIT) for Smoking Cessation, also failed to meet their primary goals for smoking reduction and cessation. Similarly, the results to date from numerous worksite-based cessation projects suggest either no impact or a small net effect (summarized in Chapter 4).

As these studies were under way in the 1970s and 1980s, health promotion—an organized approach to changing social, economic, and regulatory environments—emerged as a more effective mechanism for population behavior change than traditional health education. Although the aforementioned

community-based research projects used a health promotion perspective, they lacked the reach and penetration required for effective social change. In any event, the results made clear the distinction between a specific program (even one using multiple modalities) and a comprehensive multimessage, multichannel approach that used some or all of the modalities described in Chapters 3 through 6.

On a broader scale, other social initiatives can also serve some of these same purposes through means that are not directly related to changing population behavior. For example, direct advocacy—the presentation of information to decision makers to encourage their support for nonsmoking policies—has been pursued vigorously by health advocates since the organization of grassroots movements for nonsmokers' rights in the early 1970s. Much of the clean air legislation now in place may be attributed in part to such direct advocacy. An interesting observation that supports the logic behind comprehensive programs is that initial shortcomings in direct advocacy activity may have been related to a failure of coordination among grassroots groups and professional organizations. In recent years, in part as the result of electronic networking and mediating by the Advocacy Institute, a more unified approach to reducing tobacco use has been achieved among the participating organizations.

Media advocacy—the use of mass media to advance public policy initiatives—has also been effective in placing smoking issues in the public eye and maintaining a continued impetus for reducing tobacco use. Case analysis of several instances of such activity—advocacy opposing the promotion of the "X" cigarette, the marketing of "Dakota" cigarettes, the Philip Morris-sponsored Bill of Rights tour, and the attempted marketing of "Uptown" cigarettes—highlights several successes but also indicates that such activities do not always achieve their immediate aims. Nonetheless, considerable experience has been gained in seizing such opportunities.

Countermarketing activities can promote smoking cessation and decrease the likelihood of initiation. Countermarketing campaigns also can have a powerful influence on public support for tobacco control activities and provide an educational climate that can enhance the efficacy of school- and community-based efforts. For youth, the CDC has estimated that the average 14-year-old has been exposed to more than $20 billion in imagery advertising and promotions since age 6, creating a "friendly familiarity" for tobacco products. The recent increase in movie depictions of tobacco use further enhances the image of tobacco use as glamorous, socially acceptable, and normal. In light of the ubiquitous and sustained protobacco messages, countermarketing campaigns need to be of comparable intensity and duration to alter the general social and environmental atmosphere supporting tobacco use.

Perhaps the most important aspect of comprehensive programs has been the emergence of statewide tobacco control efforts as a laboratory for their development and evaluation. The number of states with such programs grew slowly in the early and mid-1990s, but in recent years there has been a surge in funding for such efforts fueled by the state settlements with the tobacco industry. Although the data on the impact of these programs on per capita consumption, adult prevalence, and youth prevalence are generally favorable, the uniform data systems needed to conduct more controlled evaluations of these efforts are still emerging. Nevertheless, the Institute of Medicine (2000) has concluded that these "multifaceted state tobacco control programs are effective in reducing tobacco use" (p. 4). The challenge for the new millennium will be to ensure that these ever-increasing comprehensive statewide tobacco control programs are as efficient and effective as possible.

The review of statewide tobacco control programs indicates that reducing the broad cultural acceptability of tobacco use necessitates changing many facets of the social environment. In addition, this report stresses—as does the *Best Practices* document—that these individual components must work together to produce the synergistic effects of a comprehensive program. However, both of these findings highlight the complexity involved in evaluating these types of programs.

Within the current statewide tobacco control programs, each of these various modalities discussed in this report is represented with varying degrees of intensity. As noted above, some of the recommendations for actions within these modalities could most effectively be done at the national rather than the state level. Thus, the overall efficacy of these emerging statewide programs will depend in some ways on public health advances at the national level. Again, this synergy between the statewide and national efforts adds greater complexity to the evaluation issue.

Finally, this report concludes that the span of impact of these educational, clinical, regulatory, economic, and social approaches indicates the importance of their sustained and long-term implementation. Program evaluation and research efforts are needed to improve our understanding of how these various elements work. Although knowledge about the efficacy of comprehensive programs is imperfect, evidence points to early optimism for their continuance. With the expansion of tobacco control surveillance and evaluation systems and increases in the number and

diversity of statewide tobacco control programs, critical questions can be answered about how to make these efforts more efficient and effective.

A Vision for the Future—Reducing Tobacco Use in the New Millennium (Chapter 8)

In its assessment of the trajectory of tobacco control activities in the coming years, the report focuses on six future challenges: the scientific base, the changing tobacco industry, the need for comprehensive approaches, identifying and eliminating disparities, improving dissemination of interventions, and influencing tobacco use in developing nations.

Continuing to Build the Scientific Base

Beginning with the 1964 Surgeon General's report, *Smoking and Health*, tobacco control policy in this nation has been built on a foundation of scientific knowledge. Each of the subsequent 24 reports of the Surgeon General on tobacco use has documented a vast and growing body of scientific literature. The substantial research reviewed in this report focuses on a key segment of the literature—what has been tried in the decades-old effort to reduce tobacco use. In turn, this focus clarifies which efforts work best. Certainly more research is needed so that these efforts can be more efficient and effective; the key conclusion from this report, however, is that we know more than enough to take actions now to decrease the future health burden of tobacco-related disease and death in this country.

In the process of applying our current state of knowledge about preventing and controlling tobacco use, accountability and evaluation of the public health effort will be critical. However, because of the wide array of educational, clinical, regulatory, economic, and social influences that have and will need to be brought to bear on the tobacco use problem, the direct impact of a specific maneuver on a specific outcome becomes less meaningful as the combined effects become more substantial. Investigators tend to work on small, manageable aspects of the tobacco use problem, but the synergistic influence of multiple factors over time will likely extend far beyond the outcomes predicted from these smaller research undertakings. For example, as this report demonstrates, the most efficacious educational programs are those that take place in a larger community context, one that engenders and supports an environment of nonsmoking. Similarly, although clinical interventions to manage tobacco addiction clearly have some specific power to help smokers quit, primarily through pharmacologic means, the social environment remains a major determinant of whether these new former smokers maintain their abstinence from nicotine addiction. Regulatory efforts, on the other hand, raise a host of social and economic issues and can produce broad societal changes—issues and changes, however, that are difficult to isolate, document, and evaluate. Economic strategies also have a great potential, but being fundamentally political in nature, they require public consensus and changes in social norms before they can be attempted. Finally, the public health advocacy involved in social program modalities is virtually impossible to assess in a prospective or controlled research design.

The research and evaluation tools of public health must expand to meet these complex issues. Comprehensive, multifactorial approaches to tobacco control appear to offer the most promise. However, the penalty for comprehensive approaches is a loss of statistical power to attribute outcomes to specific activities. Within each of the modalities, appropriate evaluation methodologies are being used. However, many of these methodologies involve retrospective case study, time trend, econometric, and surveillance approaches to evaluate the "natural experiment" as it evolves in the changing social environment. Thus, the traditional biomedical and epidemiologic research methods that have worked so well in defining the health consequences of tobacco use are not well suited to evaluate the potentially most efficacious methods to reduce tobacco use.

The Changing Tobacco Industry

This report documents that this country's efforts to prevent the onset or continuance of tobacco use have faced the pervasive, countervailing influences of tobacco promotion by the tobacco industry. Despite the overwhelming and continually growing body of evidence of adverse health consequences of tobacco use, the norm of social acceptance of tobacco use in this nation has receded more slowly than might be expected, in part because of such continued promotion.

Litigation and legal settlements have produced notable changes in the tobacco industry's public positions on health risks, nicotine addiction, and advertising and promotion limits. Additionally, individual manufacturing companies have become more directly involved in efforts to limit the access of underage persons to tobacco products and to prevent young people from initiating tobacco use. In this rapidly changing social and legal environment, it is difficult to project

the nature and scope of future changes by the industry or their impact on the national effort to reduce tobacco use. Nevertheless, any analysis of changes in patterns of tobacco use must consider the influence of these industry changes.

One of the major arenas of potential change will be in the tobacco product itself. The manufactured cigarette that is widely marketed in the developed world was noted to be changing dramatically when this issue was first considered by the Surgeon General in 1981, *The Changing Cigarette* (USDHHS 1981). Recent public statements by the tobacco industry suggest that the pace of changes in the manufactured cigarette could be accelerating in the future. The public health implications of changes in manufactured cigarettes and other tobacco-containing products will require careful and significant attention from both public health researchers and policymakers.

The litigation environment has demonstrated the importance of tobacco industry documents in analyzing the industry's influence. Legal and public health analyses are just beginning to sift through the millions of pages of documents made public as part of the various legal actions undertaken over the last decade. As this process continues, public health researchers may develop better methods to define and evaluate the industry's past activities that may have contributed to the character, pace, or direction of changes in tobacco use patterns in this country or around the world.

The Need for Comprehensive Approaches

The evidence of effectiveness summarized in this report emphasizes that public health success in reducing tobacco use requires activity using multiple modalities. A comprehensive approach—one that optimizes synergy from applying a mix of educational, clinical, regulatory, economic, and social strategies—has emerged as the guiding principle for future efforts to reduce tobacco use. The public health goals of such comprehensive programs are to reduce disease, disability, and death related to tobacco use through prevention and cessation, as well as through protection of the nonsmoker from ETS.

The emerging body of data on statewide tobacco control efforts is coming from programs broadly focused on prevention, cessation, and protection of the nonsmoker from ETS (Chapter 7). Preventing initiation among young people is a primary goal of any tobacco control effort. However, young people will perceive contradictory or inconsistent messages in our prevention efforts if programs do not also address the smoking behavior of millions of parents and other adult role models and the public health risks of ETS.

CDC recently released *Best Practices for Comprehensive Tobacco Control Programs* (CDC 1999), which recommends that states establish tobacco control programs that are comprehensive, sustainable, and accountable. This document draws on "best practices" determined by evidence-based conclusions from research and evaluation of such comprehensive programs at the state level. In the review of evidence from these states, it was evident that reducing the broad cultural acceptability of tobacco use necessitates changing many facets of the social environment. Nine specific elements of a comprehensive program are defined in the guidance document. Although, the importance of each of the elements is highlighted, the document stresses that these individual components must work together to produce the synergistic effects of a comprehensive program.

Best Practices thus provides effective guidance for state-level efforts; a comprehensive national tobacco control effort, however, requires strategies that go beyond this guidance to states. Moreover, a comprehensive national effort should involve the application of a mix of educational, clinical, regulatory, economic, and social strategies. In each of these modalities, some of the program and policy changes that are needed can be addressed most effectively at the national level.

Identifying and Eliminating Disparities

The elimination of health disparities related to tobacco use poses a great national challenge. Although this issue was not a major aspect of the current report, two other recent USDHHS publications have taken this focus. The 1998 Surgeon General's report *Tobacco Use Among U.S. Racial/Ethnic Minority Groups* was the first to address the diverse tobacco control needs of the four major U.S. racial/ethnic minority groups—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics (USDHHS 1998). Similarly, *Healthy People 2010*, released in January 2000, has two overarching goals: increase quality and years of healthy life and eliminate health disparities among different segments of the U.S. population (USDHHS 2000a). Both publications not only highlight the significant disparities in health that exist in the United States but also stress the critical need for a greater focus on this issue, both in research and in public health action.

Cultural, ethnic, religious, and social differences are clearly important in understanding patterns of tobacco use, but little research has been completed

on the relative effectiveness of interventions for prevention and treatment in some of the population groups or communities. Reaching the national goal of eliminating health disparities related to tobacco use will necessitate improved collection and use of standardized data to correctly identify disparities in both health outcomes and efficacy of prevention programs among various population groups. Broader historical, societal, and community characteristics can have a significant influence on the manner in which prevention and control strategies that work overall for the population as a whole may impact diverse groups. Many of these broader variables do not lend themselves to traditional measurement methods nor are they easily assessed at the individual level through using traditional epidemiologic methods.

Improving the Dissemination of State-of-the-Art Interventions

One of the greatest challenges in tobacco control and public health in general continues to be overcoming the difficulty in getting advances in prevention and treatment strategies effectively disseminated, adopted, and implemented in their appropriate delivery systems. Simply stated, our recent lack of progress in tobacco control is attributable more to the failure to implement proven strategies than it is to a lack of knowledge about what to do. The result is that each year in this nation, more than 1 million young people continue to become regular smokers, and more than 400,000 adults continue to die prematurely from tobacco-related diseases.

Within each of the modalities reviewed in this report, some specific research advances in tobacco prevention and control strategies have not been fully implemented. Studies are urgently needed to identify the social, institutional, and political barriers to the more rapid dissemination of these research advances. Understanding these barriers and determining how they could be overcome would benefit not only tobacco control but public health efforts more broadly.

Tobacco Use in Developing Nations

Analyses by the World Health Organization (WHO) have concluded that by 2030, current smoking patterns will produce about 500 million premature deaths from tobacco-related disease among people alive today (WHO 1999). WHO further estimates that by 2030, tobacco is expected to be the single greatest cause of death worldwide, accounting for an estimated 10 million deaths per year. Although the impact of tobacco-related disease and death has been until recently a problem primarily for the developed countries of this world, WHO now estimates that by 2020, 7 of every 10 tobacco-related deaths will be in the developing world.

This report addresses research on strategies to reduce tobacco use within our nation's social, legal, and cultural environments. Nevertheless, findings from this report may have broad utility in the planning of tobacco control efforts around the world. As Chapter 2 documents, the public health response in this country to the scientific findings about the health consequences of tobacco products has taken more than four decades to emerge. In many parts of the developing world, the problems of tobacco use are similar to those in this country in the 1950s and 1960s. Hence, a key public health question for this millennium may be the following: can the time interval be significantly shortened between when the health risks of tobacco for a developing country are recognized and when a comprehensive national response is begun?

WHO, the World Bank, and the United Nations Foundation, with technical assistance from the CDC, have undertaken major new initiatives to address this problem. The WHO Tobacco Free Initiative is developing an international tobacco control infrastructure, which includes a global tobacco surveillance system, intervention tool kits, and regional technical assistance workshops. The World Bank has published *Curbing the Epidemic: Governments and the Economics of Tobacco Control* (Jha and Chaloupka 1999). This document provides an economic analysis that supports a multipronged approach to tobacco control, involving raising excise taxes, promoting policy changes related to the sales and promotion of tobacco products as well as to restrictions on smoking in public places, and widening access to smoking cessation therapies. The scientific findings in this report are consistent with the programmatic recommendations of both the WHO Tobacco Free Initiative and the World Bank document.

A momentous undertaking of WHO and member states, including the United States, is the development and negotiation of the Framework Convention on Tobacco Control. If brought to its intended ratification in the next few years, this agreement would provide a framework within which countries could develop more specific bilateral and multilateral protocols for cooperation on containing the spread of the tobacco epidemic. The framework would enable countries to start from a common understanding of the issues, priorities, and strategies necessary to harmonize tobacco control efforts among themselves so that some countries do not benefit at the expense of others. This is the spirit of the other activities of U.S. governmental

and nongovernmental agencies in their effort to collaborate with WHO and with other countries in their development of surveillance, cessation, prevention, mass media, regulatory, economic, and social approaches to global tobacco control.

In the near future, emphasis must be placed on the development of surveillance systems so that countries can know the extent, distribution, and trends of the tobacco consumption problems in their populations. These systems will also track—for international comparison and monitoring of progress—the emergence of new forms of tobacco promotion, as well as new legislation, regulations, and programs for countering tobacco use. In the longer term, the gaps must be filled in each country's defenses against the incursions of tobacco use on their young people and other vulnerable populations. In particular, there will be a continuing need to ensure that the rapidly expanding knowledge about the efficacy of various tobacco control modalities be made available to the developing world.

The challenge to the world is to prevent tobacco use, particularly smoking, from ever becoming the leading cause of preventable illness and death in the world. Dr. Gro Harlem Brundtland, the current director-general of WHO, clearly defined this challenge when she stated, "If we do not act decisively, a hundred years from now our grandchildren and their children will look back and seriously question how people claiming to be committed to public health and social justice allowed the tobacco epidemic to unfold unchecked" (Asma et al., in press).

Tobacco Control in the New Millennium

Tobacco use will remain the leading cause of preventable illness and death in this nation and a growing number of other countries until tobacco prevention and control efforts are commensurate with the harm caused by tobacco use. This report provides the composite review of the major methods—educational, clinical, regulatory, economic, and social—that can guide the development of this expanded national effort. This report is, therefore, a prologue to the development of a coherent, long-term tobacco policy for this nation.

References

Asma S, Yang G, Samet J, Giovino G, Bettcher DW, Lopez A, Yach D. Tobacco. In: *Oxford Textbook of Public Health*, in press.

Centers for Disease Control and Prevention. Guidelines for school health programs to prevent tobacco use and addiction. *Morbidity and Mortality Weekly Report* 1994;43(RR-2):1–18.

Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—August 1999*. Atlanta: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1999.

Environmental Protection Agency. *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders*. Washington: Environmental Protection Agency, Office of Research and Development, Office of Air and Radiation, 1992. Publication No. EPA/600/6-90/006F.

Fiore M, Bailey W, Bennett G, Bennett H, Cohen S, Dorfman SF, Fox B, Goldstein M, Gritz E, Hasselblad V, Heishman S, Heyman R, Husten C, Jaén CR, Jorenby D, Kamerow D, Kottke T, Lando H, Mecklenburg R, Melvin C, Morgan G, Mullen PD, Murray E, Nett L, Orleans CT, Robinson L, Stitzer M, Tommasello A, Villejo L, Wewers ME, Baker T. *Treating Tobacco Use and Dependence*. Clinical Practice Guideline. Rockville (MD): US Department of Health and Human Services, Public Health Service, 2000.

Institute of Medicine. *State Programs Can Reduce Tobacco Use*. A Report of the National Cancer Policy Board. Washington: National Research Council, 2000.

Jha P, Chaloupka FJ. *Curbing the Epidemic: Governments and the Economics of Tobacco Control*. Washington: World Bank, 1999.

Lynch BS, Bonnie RJ, editors. *Growing Up Tobacco Free: Preventing Nicotine Addiction in Children and Youths*. Washington: National Academy Press, 1994.

Myers ML, Iscoe C, Jennings C, Lenox W, Minsky E, Sacks A. *Staff Report on the Cigarette Advertising Investigation*. Washington: Federal Trade Commission, 1981.

Pirkle JL, Flegal KM, Bernert JT, Brody DJ, Etzel RA, Maurer KR. Exposure of the US population to environmental tobacco smoke: the Third National Health and Nutrition Examination Survey, 1988 to 1991. *Journal of the American Medical Association* 1996;275 (16):1233–40.

Rothenberg RB, Koplan JP. Chronic disease in the 1990s. *Annual Review of Public Health* 1990;11:267–96.

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

US Department of Health and Human Services. *The Health Consequences of Smoking: The Changing Cigarette. A Report of the Surgeon General*. Rockville (MD): US Department of Health and Human Services, Public Health Service, Office on Smoking and Health, 1981.

US Department of Health and Human Services. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. Washington: US Department of Health and Human Services, Public Health Service, 1991. DHHS Publication No. (PHS) 91-50212.

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

US Department of Health and Human Services. *Healthy People 2010* (Conference edition, in two volumes). Washington: US Department of Health and Human Services, 2000a.

CONT

NEXT FICHE

US Department of Health and Human Services. *9th Report on Carcinogens*. Research Triangle Park (NC): US Department of Health and Human Services, Public Health Service, National Toxicology Program, 2000b.

World Health Organization. *The World Health Report 1999: Making a Difference*. Geneva: World Health Organization, 1999

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Comprehensive Programs

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the FDA lacks jurisdiction to regulate tobacco products as customarily marketed. Following this decision, the FDA immediately began the process of terminating the contracts with state agencies and shutting down its enforcement program. The full discussion of this program is provided in Chapter 5.

States Currently Funded in the Nationwide Program to Reduce Tobacco Use

In 1998, 49 state health departments and the District of Columbia received funding from the USDHHS for activities to reduce tobacco use. The NCI's ASSIST project provided 17 states with approximately $21.5 million, and the CDC's IMPACT program funded 32 states and the District of Columbia with approximately $12 million. In February 1998, the CDC and the NCI were given joint responsibility to assist states and national organizations in amalgamating the findings of comprehensive research projects, the CDC and NCI programs, and the state and local programs funded by tax initiatives and legal settlements with the tobacco industry. This process will continue the evaluation of a national program that includes all states, the District of Columbia, territories, and tribes and aims to bring synchrony and coherence to the efforts of all groups working to reduce tobacco use.

In May 1999, the CDC launched the National Tobacco Control Program (NTCP) transitioning funding through various federal initiatives into one national program. The purpose of the NTCP is to build and maintain a coordinated national effort to reduce the health and economic burden of tobacco use. Federal funding is intended to support core public health tobacco control functions or to enhance existing tobacco control programs within state and territorial health departments. The program framework is based on the comprehensive tobacco control framework outlined earlier in the chapter (see "Description of Comprehensive Programs"). The NTCP funds tobacco control programs in all states, the District of Columbia, and seven U.S. territories. The NTCP also includes initiatives to fund American Indian tribal organizations to develop or improve tobacco-related regional resource networks and outreach to tribes. In 2000, the NTCP launched a new initiative to aid in the elimination of disparities in health status and outcomes among populations as it relates to tobacco use. In fiscal year 1999, the NTCP awarded $50 million to 50 states, the District of Columbia, and seven territories for a five-year cooperative agreement starting June 1, 1999, to May 30, 2004. In fiscal year 2000, funding to the states, the District of Columbia, and territories totaled $59 million. The average award for states and the District of Columbia is $1.13 million. The average award for territories is $140,000. The total includes supplemental awards of $499,400 for asthma and ETS, funded in conjunction with the Environmental Protection Agency, and $244,000 for Smoke Free Kids and Soccer. The state awards almost close the funding gap between the former NCI-funded states (ASSIST) and the other states. States with excise tax or settlement-funded programs are required to match federal funds 4 to 1. For all others, the match is 1 to 10.

Examples of Major State Programs

State coalitions have encouraged both legislation and voters' initiatives to raise state excise tax levels on tobacco products and earmark some portion of the new revenue for tobacco prevention and control programs (Shultz et al. 1986, Nicholl 1998). In 1985, the Minnesota Coalition for a Smoke Free Society 2000 led a legislative effort that was the first to pass tobacco use prevention legislation that centered on an increase in the state cigarette excise tax. Since 1985, more than 40 other states have increased their excise tax on cigarettes, as part of the appropriations process, some of these states have also funded selected tobacco control activities with this revenue increase. One such state—Maine—in May 1997 legislated an excise tax increase that earmarked funds for a more comprehensive tobacco control program.

In some states, voters' initiative process, rather than the legislative process, has been the primary mechanism by which new revenue from an excise tax increase of tobacco products has been earmarked for tobacco prevention. Voters in 24 states and the District of Columbia are permitted to sign petitions that place a proposed law on the state ballot for referendum (Nicholl 1996). Since 1988, in eight such states, coalitions have tried to use the voters' initiative process to fund statewide tobacco control programs. State coalitions were successful in winning voter approval in four of these states: California in 1988, Massachusetts in 1992, Arizona in 1994, and Oregon in 1996. Initiatives were unsuccessful in Montana (1990), Nebraska (1992), Arkansas (1992), and Colorado (1994) (Moon et al. 1993; Ross 1996; Nicholl 1998).

The four state programs funded by successful voters' initiatives are described in the next sections of this chapter. They follow discussions of the two state programs (in Minnesota and Maine) that were established by legislated appropriations for a comprehensive tobacco control plan.

Minnesota

In 1975, Minnesota was one of the first states that passed statewide comprehensive legislation for clean indoor air. In 1983, the Commissioner of Health formed the Center for Nonsmoking and Health, which oversaw the development of *The Minnesota Plan for Nonsmoking and Health* (Minnesota Department of Health 1984) by a multidisciplinary technical advisory committee in 1984. In that same year, nearly 30 public and private organizations within the state formed the Minnesota Coalition for a Smoke Free Society 2000.

By drawing increased attention to the hazards of smoking and of ETS exposure, the Minnesota Department of Health, together with civic and community leaders, stimulated legislation to implement the recommendations of *The Minnesota Plan for Nonsmoking and Health*. The legislative history and debate surrounding the passage of the resulting 1985 comprehensive legislation for preventing tobacco use have been summarized by Shultz and colleagues (1986). The legislation provided for an increase in the state cigarette excise tax from $0.18 to $0.23, with one cent of the revenue increase earmarked for a public health fund, approximately one-half of which was to be set aside for preventing tobacco use. Further, this legislation authorized the Commissioner of Health to launch a major statewide initiative—the Minnesota Tobacco-Use Prevention Initiative—to promote nonsmoking and established state aid for school-based programs to prevent tobacco use.

The legislation allocated funding to support the school-based programs at the rate of $0.52 per student during the 1985–1986 school year and $0.54 per student during future years. School districts were authorized to use these new funds for staff in-service training, curricula and materials, community and parent awareness programs, and evaluation.

Three principles guided the state's tobacco control programs. First, a broad base of public support was developed by the collaboration of the Minnesota Coalition for a Smoke-Free Society 2000, the Association for Nonsmokers—Minnesota, voluntary health agencies, health professionals, and insurers. Second, the program maintained a positive approach that stressed the consequences of tobacco use rather than attacked the tobacco industry or blamed smokers. Third, the program focused on preventing tobacco use among adolescents and young women who had not yet become addicted to cigarettes or smokeless tobacco.

The mass media campaigns were the most visible component. The campaigns included paid television, radio, and outdoor/transit advertising directed at two target populations: 12- to 13-year-old boys and girls and 18- to 24-year-old women. The goal of the media campaign was to change a social climate that encouraged the use of tobacco. Advertisements focused on increasing the awareness of the negative aspects of tobacco use that are most important to young people—unpleasant social and personal consequences such as bad breath, smelly clothes, and addiction.

To foster community tobacco control programs, *The Minnesota Plan for Nonsmoking and Health* recommended that schools, health services, and other community organizations be involved in providing prevention and education programs about tobacco use. A granting program was established in 1986 to fund 21 proposals from local organizations that could demonstrate a coordinated approach for involving multiple local organizations in the prevention effort. A second cycle of local projects was funded in 1988.

Schools throughout the state were involved in an intensive effort to plan, implement, and evaluate effective programs for students from kindergarten (K) to grade 12 and in technical institutes. Since the start of these programs in the 1986–1987 school year, the percentage of school districts addressing smoking in grades K–4 steadily increased but remained fairly constant in grades 5–10. The number of school districts in the state with a tobacco-free policy, however, steadily increased.

Each of the main program elements funded by the Minnesota Tobacco-Use Prevention Initiative has been evaluated (Minnesota Department of Health 1989, 1991). Youth and adults targeted by the program were aware of the media campaign, and the evaluation data suggested that the campaign improved young people's attitudes toward tobacco use (Minnesota Department of Health 1991). There was a steady increase in the number of school districts whose curricula included components for preventing tobacco use (Minnesota Department of Health 1991). Nonetheless, a prospective study indicated that schools using the prevention curricula were not more effective in reducing adolescent tobacco use than were a randomized control group of schools (Murray et al. 1992). In that study, a comparison of trends in adolescent tobacco use in Minnesota and Wisconsin between 1986 and 1990 found a slightly larger (but nonsignificant) net decline in Minnesota. The investigators suggested that greater reach and penetration of preventive efforts may be required to produce statewide reductions in adolescent tobacco use (Murray et al. 1992).

California

In November 1988, the Tobacco Tax and Health Promotion Act (Proposition 99) was passed by California voters, thus mandating the start of California's Tobacco Control Program. The program is the largest and most comprehensive undertaken in the United States to reduce tobacco use. Initially, the program defined three long-term objectives: (1) to reduce the initiation of cigarette smoking by children and youth under age 19 from the 1987 rate of 26.4 percent to no more than 6.5 percent by 1999, (2) to reduce cigarette smoking among adults aged 20 years and older from the 1987 rate of 26.0 percent to 6.5 percent by 1999, and (3) to reduce smokeless tobacco use among males aged 12–24 years from the 1987 rate of 8.9 percent to no more than 2.2 percent by 1999 (Tobacco Education Oversight Committee 1991). The excise tax rate on cigarettes in California rose from $0.10 to $0.35 on January 1, 1989, when Proposition 99 was implemented. On January 1, 1994, the tax increased to $0.37, where it remained in 1999. Funding for tobacco control efforts began during fiscal year 1989 (July 1989–June 1990). The fiscal year 1999 budget in California was $126.8 million ($3.90 per capita) for tobacco control activities funded by the Department of Health Services and the Department of Education.

The NCI's planning framework (NCI 1991) was used to establish the program's target groups, intervention channels, and interventions to reach them (Bal et al. 1990). Community mobilization is a key part of California's extensive program for reducing tobacco use. Community-based programs are the responsibility of the California Department of Health Services and 61 local health departments (58 county and 3 city). These local agencies, advised by local coalitions, established multiple subcontracts with community-based organizations to conduct events, programs, and presentations for diverse racial and ethnic groups (Tobacco Education Oversight Committee 1991). Local lead agencies have been a cornerstone of the program by mobilizing communities to eliminate exposure to ETS, by closing channels for minors' access to tobacco, and by advising local policymakers. The local lead agencies receive approximately 20 percent of funds allocated for education programs to achieve these ends.

The statewide media campaign, which receives about 12 percent of funds, has been the program's most visible element. Launched in 1990, the media campaign has focused primarily on changing public opinion to denormalize tobacco use. In particular, it has sought to raise public awareness of the tobacco industry's manipulative and deceptive marketing tactics and of the dangers of ETS. Although young people are a direct target audience for some campaign messages, the campaign has focused more on changing social norms and reducing adult tobacco use to influence youth, many of whom begin using tobacco to be more adultlike. Funding for the statewide media campaign was about $24 million ($0.75 per capita) in 1998 but has varied considerably over the years, as is discussed later in this section.

About 16 percent of education funds are spent on competitive grants to community-based organizations. More than two-thirds of these grants have targeted racial and ethnic minority communities. The competitive grants program has had multiple funding cycles, and 46 separate projects were funded in 1993. In addition, the competitive grants program funds several statewide projects, such as the Tobacco Education Clearinghouse of California, which distributes library and video materials, and the California Tobacco Control Resource Partnership, which provides technical assistance and training to local lead agencies. The competitive grants program has also been used to establish regional linkages among local governments and local nongovernmental organizations. Twenty-four percent of the education funds go to school-based programs to prevent tobacco use and are distributed through the California Department of Education. The project estimated that it would reach approximately 350,000 students through programs implemented between 1994 and 1996.

The single largest share, by far, of the education funds—59 percent through 1996—goes to the medical care programs. This percentage is notably higher than the 45 percent specified by the legislation (Novotny and Siegel 1996). As a result of this redistribution, the portions of the program that deal with reducing tobacco use—designated for 20 percent of the funds—have never been fully financed. In the first year, 16.5 percent of funds were allocated for such program efforts; in the second cycle, 12 percent were allocated, in the third, 10 percent. This diversion of funds was the result of executive decisions and was strongly supported by the tobacco industry and the California Medical Association. After the third diversion, civil action was initiated by Americans for Nonsmokers' Rights, supported by the American Lung Association and the ACS, to prevent the reallocation. The Sacramento Superior Court found in favor of the plaintiffs in early 1995. The state appealed, and the judgment for the plaintiffs was upheld in December 1996 (*Americans for Nonsmokers' Rights v. State of California*).

The complicated course of these events, as detailed by Novotny and Siegel (1996), has highlighted

the role of the tobacco industry in countering efforts to reduce the use of its products and the opposing strategy of health advocates. Begay and colleagues (1993) have pointed out that since Proposition 99 passed, the tobacco industry's political expenditures in California have risen tenfold, from $790,050 in the 1985–1986 election to $7,615,091 in the 1991–1992 election, during which the tobacco industry contributed more heavily to candidates for the California legislature than to candidates for the U.S. Congress. In a further analysis, this same research group (Traynor et al. 1993) detailed the specific industry strategies to prevent local control of tobacco use. Using case studies, they documented the industry's use of front groups to conceal its involvement, its organization of local referenda to defeat or suspend local ordinances, and its financing of local election campaigns to repeal ordinances by popular vote. Glantz and Begay (1994) have also analyzed the relationship between campaign contributions and votes on individual tobacco-related bills in the California legislature. Using a "tobacco policy score" (p. 1178) that ranked legislators according to their stance for or against reducing tobacco use, they found a significant relationship between the amount of money received from tobacco sources and a pro-tobacco position. This ongoing documentation of tobacco industry influence, though not a formal part of the California Tobacco Control Program, has been one of its notable features, and it provides a model of health advocacy for other states and localities.

The program, which has evolved considerably since 1989, remains a multifocal, multichannel approach to the broad range of issues that confront large-scale efforts to reduce tobacco use (Tobacco Education and Research Oversight Committee 1995; Pierce et al. 1998a). In 1993, the California Tobacco Control Program was revised, and program priorities were refocused (Pierce et al. 1998a). Four broad priority areas, or policy themes, were established for use in the program planning and funding decisions:

- Protecting people from exposure to ETS.
- Revealing and countering tobacco industry influence.
- Reducing young people's access to tobacco products.
- Providing cessation services.

The California Tobacco Control Program continues to place its primary emphasis on a broad statewide infrastructure that reaches into communities across the state. The program's basic structure is composed of a state-level office and several statewide and regional programs that foster a collaborative grassroots approach to serve a decentralized structure of community programs across the state (Pierce et al. 1998a).

Surveillance and evaluation activities to assess program performance and impact were established as part of the initial program structure (Bal et al. 1990, Tobacco Education Oversight Committee 1991). The evaluation is composed of large triennial surveys (Pierce et al. 1994, 1998a) and smaller ongoing surveys (Pierce et al. 1998b), a more targeted evaluation of program components (Independent Evaluation Consortium 1998), and a wide array of local program evaluation efforts. Evaluation is complicated, however, by the multiplicity of prevalence surveys available and by potential error from using data from surveys with differing methods (Novotny and Siegel 1996, Siegel et al. 2000). Establishing specific relationships between large-scale social interventions and a change in tobacco use is difficult, but the temporal relationship between the decline in California's tobacco consumption and the efforts generated by Proposition 99 can be clearly observed.

Per Capita Cigarette Consumption

Before the implementation of the program in 1989, the rate of decline in monthly per capita cigarette consumption was 0.42 packs, which was significantly greater than the rate of 0.36 in the rest of the country (Pierce et al. 1998a,b). From January 1989 through December 1993, the decline in California increased significantly, to 0.65 packs, while the decline in the rest of the United States increased nonsignificantly, to 0.45 packs. Until early 1992, the media program was the only part of the tobacco control program that was fully implemented. An econometric analysis (Hu et al. 1995) has estimated that of the 1,051-million pack decrease in sales between 1990 and 1992, approximately 232 million (22 percent) were attributed to the media campaign and the remaining 819 million (78 percent) to the excise tax increase. Between 1993 and 1996, the rate of decline in per capita consumption in California slowed significantly, to 0.17, but virtually halted altogether in the rest of the country (at 0.04 packs) (Pierce et al. 1998b). Consumption decreased more rapidly in California than in the rest of the country, even though the California cigarette excise tax changed only slightly during this period (from $0.35 in 1993 to $0.37 in 1994). Between 1993 and 1996, however, expenditures for tobacco control were reduced by more than 50 percent from their initial funding levels in fiscal year 1990 and 1991. During 1989–1993, spending for advertising and promotions by the

tobacco industry exceeded tobacco control expenditures in California by a ratio of about 5 to 1; from 1993 to 1996, that ratio increased to nearly 10 to 1 (Pierce et al. 1998b).

Adult Smoking Prevalence

Data on adult patterns of smoking prevalence are not as consistent or as easy to evaluate as consumption trends (Novotny and Siegel 1996). Nevertheless, the trends in these data are consistent with the patterns noted in the per capita consumption analyses. From 1989 to 1993, smoking prevalence declined in California almost twice as rapidly as in the rest of the country (Pierce et al. 1998b). However, from 1994 to 1997, the rate of decline in California appeared to slow. Overall, smoking prevalence has declined from 26.7 percent in 1988 to 16.7 percent in 1995 in California and from 30.2 percent in 1988 to 24.7 percent in 1995 in the rest of the country (CDC 1996, Pierce et al. 1998b). A recent analysis of trends in adult prevalence of smoking in California compared with the rest of the United States observed a significant decline in smoking prevalence in California from 1985 to 1990 and a slower but still significant decline from 1990 to 1994, a period in which there was no significant decline in the remainder of the nation (Siegel et al. 2000).

Youth Tobacco Use Prevalence

The lack of consistent youth smoking surveillance data between California and other states has impeded the evaluation of program impact on tobacco use among young people in California. However, one multivariate analysis of data from the school-based Monitoring the Future survey of 8th-, 10th-, and 12th-grade students showed that from 1992 to 1994, the increase in youth smoking rates that was experienced nationwide was slowed significantly in California ($P < 0.001$, controlling for price, smoking policies, and other nonprogram effects) as a result of the combined effect of the tax increase in 1994 and the implementation of the state's tobacco control programs (Chaloupka and Grossman 1996). Pierce and colleagues (1994) have concluded that the media campaign was successful in stopping the rise in teen smoking that had been occurring in California before the campaign launch.

Results from other analyses of youth tobacco use data are consistent with the result found by Chaloupka and Grossman (1996). In data reported by the California Independent Evaluation Consortium, between 1991 and 1996 rates of smoking during the past 30 days among California youth in the 8th and 10th grades in the Monitoring the Future survey increased, but the increase in California was less pronounced than in other states (Independent Evaluation Consortium 1998). Among 8th-grade youth, since 1993 the prevalence of smoking during the past month has varied from 12 to 14 percent in California while steadily increasing from 17 to 22 percent in the rest of the country. Similarly, among 10th-grade youth, past-month smoking prevalence in California has been about 18 to 19 percent since 1992 while increasing from 22 to 32 percent in the rest of the country. Data from the telephone-based California Youth Tobacco Survey indicate that the prevalence of smoking during the past 30 days among 12- to 17-year-olds increased from approximately 9 percent in the early 1990s to 11.9 percent in 1995. Prevalence declined gradually after 1995, to 10.9 percent in 1997, while increasing in the rest of the country (Pierce et al. 1998a).

Other Findings

Since the start of the program in 1990, numerous changes in intermediate outcomes have been noted related to changes in social norms, clean indoor air policies in public places, worksites, and bars, and voluntary policies to ban smoking in homes.

Massachusetts

In November 1992, Massachusetts voters approved an initiative petition known as Question 1, establishing the Health Protection Fund with revenue generated from a 25-cent increase in the state's cigarette excise tax and a 25-cent increase in the wholesale price of smokeless tobacco products. Revenues have been used to fund the Massachusetts Tobacco Control Program, a comprehensive set of activities and services that emphasize prevention programs at the local level and that focus on young people. The Massachusetts program was modeled, in part, on California's program. The overall goal of the program was to reduce tobacco use in Massachusetts by 50 percent by the end of 1999 (Abt Associates Inc. 1995). With the passage of Question 1, the excise tax on cigarettes in Massachusetts rose from $0.26 to $0.51 on January 1, 1993. This tax was fully absorbed by the industry through wholesale price reductions (CDC 1996). However, in October 1996 the cigarette tax increased to $0.76 per pack (with comparable increases on smokeless tobacco products), where it currently remains.

Funding for tobacco control efforts began with a large media campaign in October 1993. In late 1993 and early 1994, funding for local agencies was begun, and several statewide initiatives were undertaken to provide direct services, as well as technical assistance,

training, and materials for localities. Starting in late 1994, with the first year of complete implementation, the program received $43.1 million (33.7 percent) of the $127.8 million placed in the Health Promotion Fund created by the revenues from the excise tax increase. Other key programs receiving appropriations from the Health Promotion Fund were those for comprehensive school health education ($28.8 million, or 22.5 percent of the Health Promotion Fund in fiscal year 1995), drug education ($5.0 million, or 3.9 percent), and other health-related programs ($50.7 million, or 39.7 percent) (Abt Associates Inc. 1995). After the first funding year, the program's budget declined to $41.8 million in 1995-1996 and to $36.8 million in 1996-1997. Funding was increased for other programs receiving appropriations from the Health Promotion Fund (Abt Associates Inc. 1997).

Community-based education activities and prevention activities are two main elements of the Massachusetts program. The state's 10 regionally based, primary care Prevention Centers have added a component for reducing tobacco use and provide ongoing technical assistance and training to local community programs. Local community initiatives have included programs to increase community awareness about the hazards of tobacco use, to promote tobacco-free workplaces and public facilities, and to enforce local regulations and ordinances for reducing tobacco use; needs assessments in the community; mobilization of youth service agencies to prevent and reduce tobacco use among children and adolescents; funding of community-based agencies to work with at-risk adult populations, including cultural and linguistic minority groups, women of childbearing age, and blue-collar workers; and funding of school-based health centers (Abt Associates Inc. 1995).

Per Capita Cigarette Consumption

As in California, Massachusetts has experienced a persistent pattern of decline in per capita cigarette consumption. Before the 1993 implementation of these tobacco control programs, per capita cigarette consumption was declining in Massachusetts at a rate approximately equivalent to that of the rest of the country (6.4 percent in Massachusetts and 5.8 percent in the states other than California [CDC 1996]). Between 1992 and 1997, per capita consumption in Massachusetts declined by 31 percent (from 117 to 81 packs per adult), while the decline in the remaining 48 states was only 8 percent (Abt Associates Inc. 1997). Between 1993 and 1996, the decline in per capita consumption has been more consistent in Massachusetts than in California (CDC 1996). Although program funding declined about 15 percent in Massachusetts from 1995-1996 to 1996-1997 (Abt Associates Inc. 1997), it declined less than in California.

Adult Smoking Prevalence

Adult smoking prevalence has been monitored in Massachusetts both by the annual survey conducted through the Behavioral Risk Factor Surveillance System (BRFSS) and by special Massachusetts Adult Tobacco Surveys conducted in 1993, 1996, and 1997. Data from the BRFSS indicate that adult smoking prevalence in Massachusetts declined from an average of 23.5 percent for 1990–1992 to 20.6 percent in 1997. In the rest of the country (excluding California), prevalence declined from 24.1 percent in 1990-1992 to 23.4 percent in 1993-1995 (CDC 1996, Abt Associates Inc. 1997). The Massachusetts survey produced different prevalence estimates but corroborated a similar decline in the prevalence of smoking among adults in Massachusetts (from 22.6 percent in 1993 to 21.1 percent in 1996 and 20.6 percent in 1997) (Abt Associates Inc. 1997).

Youth Tobacco Use Prevalence

As in California, the observed nationwide increase in the prevalence of smoking among young people from 1992 to 1994 was significantly less evident in Massachusetts (Chaloupka and Grossman 1996). Follow-up data from the Youth Risk Behavior Survey (YRBS) indicated that the prevalence of current smoking among Massachusetts high school students (grades 9 to 12) declined from 35.7 percent in 1995 to 34.4 percent in 1997 while increasing from 34.4 to 36.4 percent nationwide (CDC 1996, 1998). Data from the YRBS and other survey sources suggest a differential pattern by age: the prevalence of current smoking increased in Massachusetts among older students in a manner similar to that of the rest of the country but declined among younger students. Between 1993 and 1996, the prevalence of smoking during the past 30 days among 8th-grade students in Massachusetts declined from 26.5 to 26.0 percent but increased from 16.7 to 21.0 percent nationwide (Briton et al. 1997). For Massachusetts, the prevalence of current smokeless tobacco use among 9th–12th graders decreased from 8.4 percent in 1995 to 6.0 percent in 1997; for males, the decline was from 15.1 to 10.3 percent (Kann et al. 1998). In the nation as a whole between 1993 and 1996, lifetime use of smokeless tobacco among 9th-12th graders decreased from 25 to 20 percent, and current use decreased from 9 to 6 percent (Briton et al. 1997). The most recent data from the 1999 YRBS in Massachusetts indicated a continuing decline in the

prevalence of current smoking, down to 30.3 percent among 9th–12th graders (Goodenow 2000); however, national comparison data for 1999 are not yet available.

A 1996 survey of 12- to 14-year-olds in Massachusetts and a national comparison sample (Houston Herstek Favat, Youth exploratory 1996, Massachusetts Department of Public Health, presentation of findings, unpublished data) found that Massachusetts youth had significantly higher levels of agreement with issues addressed in the state media campaign. For example, 59 percent of Massachusetts youth but only 35 percent of youth in the national sample agreed with the statement, "Smoking cigarettes decreases your stamina and smokers have a hard time keeping up in sports." Results from a longitudinal survey of Massachusetts youth provided additional support for the efficacy of the Massachusetts antismoking media campaign (Siegel and Biener 2000). In a four-year follow-up of youth aged 12 to 15 years in 1993, this study found that among the younger adolescents (aged 12 to 13 years at baseline), those exposed to antismoking advertisements were significantly less likely to progress to established smoking. However, among older adolescents (aged 14 to 15 years at baseline), exposure did not prevent progression to established smoking.

Other Findings

There have been multiple changes in intermediate measures of program impacts related to youth access, protection of nonsmokers from ETS, and availability of cessation services (Abt Associates Inc. 1999). For example, by 1999, nearly two-thirds of Massachusetts residents lived in cities and towns with some kind of smoking restriction in restaurants, and 26 percent were protected by complete bans. Prior to the start of the program, less than 1 percent of Massachusetts residents lived in towns with complete bans. Additionally, the local restaurant smoking restrictions were found to be more restrictive in communities receiving funding from the Massachusetts Tobacco Control Program.

Arizona

In November 1994, Arizona voters passed Proposition 200, which increased the state cigarette excise tax from $0.18 to $0.58. Revenues from the tax increase were earmarked for the state's Medicaid program (70 percent of revenues), for programs for preventing and reducing tobacco use (23 percent), for research on prevention and treatment of tobacco-related disease and addiction (5 percent), and for an "adjustment account" (Arizona Tobacco Tax and Health Care Act 1994, sec. 2C4) to offset lost revenue to other state programs currently funded by revenue from the existing $0.18 excise tax (2 percent). The petition drive to place the initiative on the November 1994 state ballot and the campaign to win voter approval was led by the Arizona for a Healthy Future coalition. Although public support for the initiative was strong when it was first proposed in 1993 (71 percent in favor, with 56 percent indicating strong support), the initiative was vigorously opposed in a well-funded advertising effort on television, in posters, and by direct mail. Proposition 200 was narrowly approved, garnering approximately 51 percent of the vote (Nicholl 1998).

With the passage of Proposition 200, analysts estimated that the revenues earmarked for tobacco prevention and education programs would be approximately $25 million per year (Meister 1998). However, measures passed during the 1995 session gave the legislature control over the funds and limited expenditures to $10 million per year (Madonna 1998). Additionally, multiple restrictions were placed on how the funds could be used, and an advisory committee was appointed that included legislative and business representatives hostile to the program (Meister 1998). Although the Coalition for Tobacco-Free Arizona led an effort to keep the goals of the newly created Arizona Tobacco Education and Prevention Program (AzTEPP) "comprehensive," the program efforts were narrowed to a focus on youth prevention; adult cessation activities were restricted to pregnant women and their partners. Not until the fiscal year that began on July 1, 1997, with a new governor and health department director, were the programmatic restrictions lifted from the health department and the program allowed to proceed with the implementation of the "draft" comprehensive tobacco control plan originally proposed by the Coalition for Tobacco-Free Arizona.

The expenditures of AzTEPP reflect the political history of the program: $9.7 million in fiscal year 1996, $18.2 million in 1997, and $28.2 million in 1998. Although the countermarketing campaign has expanded (with spending increasing from $7.4 million in 1996 to $13.2 million in 1998) (Riester and Linton 1988), the greatest expansion in the program has been in the scope and focus of the local programs (Meister 1998) (with funding increasing from $1.7 million in 1996 to $9.4 million in 1998). Recent program efforts have focused on all of the elements in the coalition's draft comprehensive tobacco control plan (Meister 1998), thereby expanding its adult cessation activities (discussed at the fourth annual AzTEPP meeting in February 1999), but one of the factors that had been minimized in early health department efforts was

evaluation. Only recently have baseline data collection surveys been initiated (Meister 1998), as a result, no outcome data have been reported on the program, and subsequent evaluation efforts will be compromised by the lack of baseline data collected before the start of the multiple large-scale program efforts.

Respondents to an initial statewide telephone survey conducted in 1998 (Arizona Cancer Center 1998), about two and a half years after the media campaign's launch, reported that the advertising campaign, which stressed how damaging tobacco use is and how unappealing it is to the user, to peers, and to the opposite sex, had influenced their attitudes in the intended direction. For example, 80 percent of young people reported that the advertisements made them think about the negative aspects of tobacco use, and 58 percent of pregnant or postpartum women said the advertisements made them uncomfortable around smokers. Young people who had been exposed to the television advertisements in the previous 30 days were less likely to be susceptible to using tobacco than were youth who had not seen the advertisements. The campaign's impact on reported behaviors is less clear, especially among young people. Among respondents who were using tobacco at the start of the campaign, 23 percent of adults, 37 percent of pregnant or postpartum women, and 27 percent of young people said the advertising campaign had convinced them to try quitting. However, 23 percent of young people also reported that the campaign had convinced them to *increase* their tobacco use. Cummings and Clarke (1998) noted that such an unintended effect, if it is real, might represent young smokers' negative reaction to a narrowly focused youth campaign with no messages directed at changing broader social norms.

In response to a request from the Arizona Joint Legislative Audit Committee, the State Auditor General conducted a performance audit of the AzTFPP (State of Arizona, Office of the Auditor General 1999). This audit noted that evaluations of the state and local levels of programs have not yet produced an adequate assessment of the program's tobacco control efforts. Thus, the audit recommended that the program needed to improve its evaluations to measure its effectiveness in preventing youth from starting to use tobacco, encouraging and assisting tobacco users to quit, and reducing exposure to secondhand smoke. Specifically, the audit found that the program had been unable to establish a baseline on tobacco use among youth and had only preliminary assessments in place to assess cessation services. The program has established adequate methodologies to measure the prevalence of adult smoking; however, follow-up results are not yet available. Thus, the audit concluded that "The program's evaluation approach to date leaves it far short of knowing whether its programs are working" (p. ii).

In response to this audit, the Arizona Department of Health Services (AzDOHS) has implemented changes in its surveillance and evaluation systems. Expanded surveillance systems for youth have been planned and will be implemented in 2000, however, no baseline data are available on youth smoking rates. For adults, a baseline survey of adults was conducted in 1996 and repeated in 1999. Using methodology similar to that used by the state BRFSS, the 1996 and 1999 Arizona Adult Tobacco Surveys were conducted by telephone interviews on representative samples of more than 4,500 adults in Arizona aged 18 years and older. Results from these surveys indicate that the prevalence of smoking among adults declined from 23.8 percent to 18.8 percent overall (AzDOHS 2000). Among adults aged 18 to 24 years, a significant decline was observed also, from 27.5 percent in 1996 to 21.0 percent in 1999. Both of these rates compare very favorably to national trends, where rates overall among adults have not declined in recent years and rates among younger adults have been increasing. Finally, smoking rates among Hispanics declined from 23.5 percent to 14.6 percent, which was the largest decline seen in any race/ethnic group in the state. Multiple other indicator variables suggest that these changes may be related to increases in smoke-free policies, advice from doctors and dentists, and exposure to television antismoking information. Finally, these declines in smoking prevalence are consistent with declines in per capita sales (Orzechowski and Walker 2000) that indicate that declines in Arizona since 1996 are larger than those observed in the rest of the country.

Oregon

On November 5, 1996, Oregon voters approved Measure 44, raising the state cigarette excise tax from $0.38 to $0.68 (with a proportional increase in the tax rate on other tobacco products) and designating 90 percent of the increased revenue for the Oregon Health Plan (to expand insurance for medically underserved state residents) and the remaining 10 percent for a statewide tobacco prevention and education program managed by the Oregon Health Division. Survey data indicated that support for the initiative was increased by having the new revenue earmarked in this way (CDC 1997; Nicholl 1998). The Oregon campaign to place the initiative on the November 1996 ballot was initially led by the Committee to Support the Oregon Health Plan, which represented

primarily the private health care sector. Nonprofit and public health organizations added their support and worked in a loosely organized network led by the ACS. Later in the campaign, both groups combined efforts and resources. The measure had strong support from state media (receiving endorsements from all major newspapers and a majority of the smaller ones), from leading business groups, and from the governor, who conducted a three-day supportive media tour before the election.

The Oregon Health Division used its existing Oregon Tobacco Control Plan as the model for the new statewide program. Revenue from Measure 44 during the 1997–1999 biennium was projected to be $170 million, of this, 10 percent (approximately $17 million) per biennium was appropriated to fund the Tobacco Use Reduction Account administered by the Oregon Health Division. The resulting Oregon Tobacco Prevention and Education Program has eight elements: (1) local community-based coalitions, (2) comprehensive school based programs, (3) statewide public awareness and education campaigns, (4) a cessation help line, (5) tribal tobacco prevention programs, (6) multicultural outreach and education, (7) demonstration and innovation projects, and (8) statewide leadership, coordination, and evaluation.

The 1997–1999 biennium budget for these eight elements is combined into five categories: (1) local coalitions—$6.5 million (38 percent), (2) public awareness and education—$4.6 million (27 percent), (3) statewide and regional projects—$2.75 million (16 percent), (4) schools—$2 million (12 percent), and (5) statewide coordination and evaluation—$1.2 million (7 percent).

Evaluation data from Oregon indicate that the program has successfully implemented each of the program elements and is achieving its performance objectives (Oregon Health Division 1999). Local community-based coalitions were created in all 36 Oregon counties. Twenty-four school projects were funded, reaching 58 of the 198 (30 percent) school districts in the state. Surveys indicated that approximately 75 percent of adults and 84 percent of the young people recalled seeing the state's public awareness campaign. In January 1999, more than 1,500 Oregonians called the cessation help line. All nine federally recognized Indian tribes in Oregon are now receiving funding to implement prevention and education programs to reduce tobacco use. Multicultural outreach and education programs have been established for Hispanic, Asian/Pacific Islander, and African American populations in Oregon. Five demonstration projects have been funded focusing on pregnant women, health care delivery systems, and creative ways to reach youth audiences. The program has also established a comprehensive and multifaceted surveillance and evaluation system and has strengthened program management.

Trends in per capita consumption in Oregon were compared with the remainder of the country (excluding California, Massachusetts, and Arizona) for the period before program implementation (1993–1996) and after (1997–1998). From 1993 to 1996, consumption increased 2.2 percent in Oregon and decreased 0.6 percent in the rest of the country (CDC 1999b). In 1997 and 1998, per capita consumption declined 11.3 percent in Oregon (from 92 to 82 packs per adult). Between 1996 and 1997, per capita consumption in the rest of the country declined only 1.0 percent (from 93 packs per adult to 92 packs per adult).

Smoking prevalence among adults in Oregon has been consistent with the observed declines in per capita consumption. Data from the BRFSS indicate that the prevalence of smoking among adults aged 18 years and older in Oregon declined from 23.4 percent in 1996 to 21.9 percent in 1998 (Oregon Tobacco Prevention and Education Program 1999). The proportion of women who smoked during pregnancy, as reported on state birth certificates, dropped from 17.7 percent in 1996 to 15.2 percent in 1998. Data suggest that smoking rates among young people are continuing to increase as in the rest of the country.

Maine

In June 1997, the Maine legislature approved LD 1357, An Act to Discourage Smoking, Provide Tax Relief and Improve the Health of Maine Citizens, which increased the state cigarette excise tax from $0.37 to $0.74 and earmarked the increased revenue for the Tobacco Tax Relief Fund. The act established the Tobacco Prevention and Control Program within the Maine Bureau of Health and provided $3.5 million in funding for fiscal years 1998 and 1999. The legislative effort to gain passage of the act was a combined effort of the state public health community, legislative leadership, and executive branch support.

The Bureau of Health has developed the Maine Tobacco Prevention and Control Program to expand the existing ASSIST program structure and to meet the legislative requirement of the 1997 state statute. The legislation specified that the program include an ongoing, major media campaign, grants for funding community-based programs; program surveillance and evaluation; and law enforcement efforts regarding transportation, distribution, and sale of tobacco products. The program's initial $4.35 million annual

budget included $1.6 million for a multimedia campaign, $1.25 million for community and school grants, $625,000 for statewide cross-cutting activities, $400,000 for state staffing, $400,000 for evaluation, and $75,000 for enforcing youth access provisions.

In April 2000, legislation was passed in Maine that appropriated additional funds to expand the Maine Tobacco Prevention and Control Program, a total of $18.3 million from the settlement is going to tobacco control. Of this total amount, $8.35 million will be used for community and school-based grants, funding communities and schools to achieve the goal of reducing tobacco addiction and use and resulting disease, with a focus on those at highest risk such as youth and disadvantaged populations. About $6.75 million will be used for cessation and statewide multimedia campaigns, $1.2 million is for evaluation for independent program evaluation, research, and outcomes monitoring, $200,000 funds five positions in the Bureau of Health for administering the programs, and $1.8 million for improved prevention and treatment of tobacco-related diseases for those with Medicaid Insurance.

Programs Funded by State Settlements With the Tobacco Industry

As was discussed earlier in this report (see "Legislative Developments" and "Master Settlement Agreement" in Chapter 5), all 50 states, the District of Columbia, and five commonwealths and territories have settled lawsuits with the tobacco industry to reclaim statewide costs spent treating Medicaid patients for diseases related to tobacco use. Four of those states settled their individual lawsuits with the industry--Mississippi in July 1997, Florida in September 1997, Texas in January 1998, and Minnesota in May 1998--and the remaining parties jointly settled in November 1998 in the multistate Master Settlement Agreement.

Because of a "most favored nation" clause (explained in "Recovery Claims by Third-Party Health Care Payers" in Chapter 5), the four separate settlements have been closely linked, particularly in how the terms of their awards affect the kind of comprehensive programs discussed in this chapter. Most notably, when the State of Florida received in its settlement $200 million that was earmarked for a two-year pilot program to reduce tobacco use among young people, the State of Mississippi, though it had settled its lawsuit earlier, received $62 million for the same type of pilot program specified in its lawsuit. Texas and Minnesota received no such additional award, because their lawsuits did not specifically set aside funds for a parallel pilot program, although Minnesota received funds earmarked for smoking cessation and tobacco-related research. Language in the Texas and Minnesota settlements, however, released Florida and Mississippi from existing requirements to use their pilot program funding within two years and to direct their programs exclusively to young people.

Because program planning in Florida and Mississippi was already in place when the youth-only restriction was removed, an emphasis on preventing tobacco use among young people has been evident in their pilot programs' first years of activities. These activities are described in the next two sections of this chapter. Brief descriptions of settlement-funded plans in Texas and Minnesota follow. This report does not attempt to describe the various plans and legislative proposals that are developing (at the time of this writing) in the 46 states, the District of Columbia, and the five commonwealths and territories included in the joint settlement of January 1998.

Mississippi

The Partnership for a Healthy Mississippi, a nonprofit corporation representing a broad range of public and private interests, plans and manages the state's pilot program. The program's mission is to create a youth-centered, statewide collaboration dedicated to fostering a healthier Mississippi and eliminating tobacco use among Mississippi youth. The partnership will award grants in five designated areas: (1) community/school youth activities and partnerships, (2) law enforcement, (3) public awareness, (4) health care services and research, and (5) evaluation.

In the first year, with a budget of $23.7 million, approximately 25 community and youth partnership coalitions were funded, and more are planned for the second year. Local coalitions--one-quarter of whose membership must be young people--are among the statewide and regional organizations supported by community assistance statewide partner grants to provide training, tobacco prevention activities for racial and ethnic minority groups, and other technical assistance. Specific programs that have been funded by the partnership are 4-H Youth Programs, Frontline (an advocacy organization for 14- to 18-year-olds), comprehensive school health programs, and a comprehensive school health nurses pilot project. In the first two years, $4 million has been allocated to these activities.

The law enforcement program has awarded grants to municipalities to enforce the Mississippi Juvenile Tobacco Access Prevention Act of 1997. These

awards will range (according to population size) from a minimum of $5,000 per municipality to a maximum of $250,000. A total of $12.65 million has been budgeted over the first two years of the program for these awards. The grants will require municipalities to conduct periodic enforcement checks on the illegal sale of tobacco to minors, provide retailer education programs, provide education programs in schools, organize youth partnerships, and work with community coalitions on enforcement issues. Other enforcement activities are being performed statewide by the Mississippi Attorney General's Office.

The partnership has budgeted $12.5 million for a countermarketing media campaign and other public awareness activities to be conducted during the first two years. The health care services and research component focuses on nicotine addiction and cessation among young people. An expenditure of $5 million is anticipated for the first and second years for training health providers in cessation counseling, for researching childhood and adolescent tobacco abuse, and for coordinating cessation services in the state, including a telephone help line. The Mississippi State Department of Health will manage the evaluation of the pilot program and will focus on program effectiveness in preventing initial tobacco use among young people, helping young people quit smoking, and reducing young people's exposure to ETS. An expenditure of $2 million is anticipated for the first and second years' evaluation activities.

Since 1998, the Partnership for a Healthy Mississippi has managed the pilot program to reduce youth tobacco use through a seven-member Board of Directors (www.healthy-miss.org) (McMillen et al. 1999). The major youth programs that have been implemented have included (1) the Reject All Tobacco (RAT) program among students in grades K–3, (2) the Students Working Against Tobacco (SWAT) Program for students in grades 4–7, and (3) the Frontline youth advocacy movement. Community programs have involved 26 community/youth partnership grants, targeted programs in collaboration with statewide organizations, and the school nurse program in 52 Mississippi school districts. Grants have funded 245 municipalities and 74 counties to empower the local law enforcement agencies to reduce sales to minors. Cessation services have included the Adolescent and Child Tobacco Treatment Center and a Mississippi Tobacco Quitline. Finally, a "Question It" public awareness campaign has focused on the 12- to 17-year-old audience.

The Mississippi State Department of Health has established a consortium of evaluation contracts involving multiple state universities to implement program evaluation efforts. The overall coordination is being managed by the Social Science Research Center at Mississippi State University, with the evaluation of the media component conducted by the University of Mississippi, community programs conducted by Jackson State University, law enforcement component by Mississippi State University, and the school nurses component by Mississippi State University (McMillen et al. 1999). A baseline Social Climate Survey of Tobacco Control and Tobacco Use was conducted in 1999 among 3,040 adults aged 18 years and older that provided benchmark data on several social norm intermediate indicator variables (McMillen et al. 1999). Surveillance of youth tobacco use patterns is being conducted by the Mississippi State Department of Health. The Youth Risk Behavior Survey was conducted among students in grades 9 to 12 in 1993, 1995, 1997, and 1999 and among students in grades 6 to 8 and 9 to 12 in 1998 and 1999. Results indicate that in Mississippi, smoking rates among students in grades 9 to 12 had been increasing, as in the rest of country, between 1993 and 1997 (Mississippi State Department of Health 2000). Between 1997 and 1999, smoking rates among students in grades 9 to 12 appear to have stopped increasing and leveled off. Among students in grades 6 to 8, smoking rates did not decline between 1998 and 1999.

Florida

Program planning and implementation initially were managed by the Governor's Office, with direct leadership provided by Governor Lawton Chiles, who was a party to the state's lawsuit and a member of the small team who negotiated the settlement agreement. The Florida Tobacco Pilot Program is now managed by the Office of Tobacco Control within the Florida Department of Health. The program has sought the input of Florida youth in planning the program focus and materials and in working toward the main goals of changing young people's attitudes about tobacco use, increasing youth empowerment through community involvement, reducing young people's access to tobacco products, and reducing youth exposure to ETS. These four goals will be addressed through program components similar to those of the Mississippi program:

- Marketing and communications initiatives are planned to directly counter the tobacco industry's marketing efforts. A commercial advertising firm, working closely with teen advisors, has developed the "Truth" campaign, a direct attack on the image of smoking as cool and rebellious. The campaign's multichannel approach—based on techniques used

by the tobacco industry—includes television, print, and billboard advertising, as well as consumer items, such as "Truth"-imprinted T-shirts and stickers.

- Youth programming and community partnership activities recruited young people to a Teen Tobacco Summit in early 1998 to advise on the overall development of the program. Chapters of Students Working Against Tobacco are currently active in all 67 counties.
- Education and training programs focus on school-aged children. Conducted in partnership with communities, schools, voluntary agencies, professional organizations, and universities, these programs ensure that effective tobacco prevention curricula are presented in middle and high schools across the state and that tobacco prevention strategies are being implemented in grades K–12 in conjunction with the Sunshine State Standards.
- Enforcement initiatives are aimed at improving Florida's efforts to reduce the accessibility of tobacco products to minors. The Florida Department of Business and Professional Regulation, Division of Alcoholic Beverages and Tobacco, provides enforcement, educational, and marketing initiatives to ensure compliance with all tobacco laws.
- The evaluation and research component monitors the performance of each of the program initiatives and the progress of the overall program in meeting goals and objectives. Under the leadership of the Florida Department of Health, and with the consultation of the University of Miami, baseline data were collected by Florida universities in all major areas before the pilot program began in early 1998.

In the first full year of operation, the program budget was approximately $70 million, with program component allocations of approximately $26 million for marketing and communications, $10 million for youth programming and community partnerships, $13 million for education and training, $8.5 million for enforcement, and $4 million for evaluation and research. An additional $5 million was budgeted for programs targeting minority populations and $3.5 million for administration and management. In the second year, approximately $45 million more was appropriated for program operations; however, there were significant unexpended funds from the first year of operations that enabled major program components, such as the marketing and communications activities, to continue a level of expenditure similar to the first year.

Youth Tobacco Use Prevalence

Between 1998 and 1999, the prevalence of current cigarette use among middle school students (grades 6 to 8) declined from 18.5 to 15.0 percent (CDC 1999c). Among high school students (grades 9 to 12) current cigarette use declined from 27.4 to 25.2 percent. However, these declines were significant only for non-Hispanic white students, the change in current smoking among non-Hispanic black and Hispanic middle and high school students was small and non-significant. Current cigar use declined significantly only for middle school students (from 14.1 to 11.9 percent), and this decline was almost entirely among males. Similarly, current smokeless tobacco use declined only among middle school students (from 6.9 to 4.9 percent) and remained unchanged among high school students.

In early 2000, additional declines in youth tobacco use were observed (Florida Department of Health 2000). Current cigarette use among middle school students declined to 8.6 percent, or an overall 54-percent decline since the 1998 baseline. Among high school students, current cigarette use declined to 20.9 percent, or an overall 24-percent decline since the 1998 baseline. Although declines between 1998 and 1999 were significant only for non-Hispanic white students, the declines observed in 2000 were significant among all racial/ethnic groups, except among the non-Hispanic black and "other" categories of high school students. Declines in current tobacco use, which include the use of cigars and smokeless tobacco, also were significant. Since the 1998 baseline survey, current cigar use declined by 46 percent among middle school students and 21 percent among high school students. Smokeless tobacco use declined by 54 percent among middle school students and by 19 percent among high school students. Declines in current tobacco use were consistent across grade, gender, and ethnicity as well.

Using additional data collected as part of the overall program evaluation, the Florida Tobacco Control Program has connected the declines in youth smoking prevalence with program activities (University of Miami 1999). Results suggest that students who reported receiving elements of a comprehensive tobacco use prevention education in school had greater declines in smoking between 1998 and 1999 than those students who reported not receiving such education in school. Similarly, the Community Partnerships in the 67 Florida counties were classified as "excellent," "average," or "needing improvement" based upon program record data, and these ratings were linked to data from the Florida Youth Tobacco Survey for

1998 and 1999 in those counties. Declines in smoking prevalence were related to the classification, with the greatest declines among middle and high school students in counties rated as "average" or "excellent." Similar ratings of counties on the level of local enforcement of youth access laws were related to youth smoking prevalence, with the highest levels of enforcement in counties with the lowest prevalence. Finally, data from the Florida Anti-Tobacco Media Evaluation (FAME) have indicated that the "Truth" campaign is producing impressive awareness among youth and changes in attitudes and knowledge consistent with the campaign themes. Between 1998 and 1999, the prevalence of Florida youth aged 16 years and under with antitobacco attitudes increased from 59 to 64 percent but decreased slightly nationwide.

National data against which to compare the Florida data from 1998 and 1999 are not yet available, but some data suggest that the prevalence of tobacco use among young people may have peaked nationwide and could be starting to decline (University of Michigan 1998). In addition, the impact of state excise tax increases that have occurred since the 1998 baseline data collection might be assessed.

Adult Smoking Prevalence

In 1998, the Florida Behavioral Risk Factor Surveillance System (BRFSS) expanded its assessment of tobacco issues. The tobacco module will enable changes to be assessed in tobacco use prevalence, cessation behaviors, family rules about tobacco use, environmental tobacco smoke exposure at home, and workplace policies regarding smoking.

Texas

The legislative plan developed by the Texas Interagency Tobacco Task Force (1998) incorporated the CDC recommendations for community and school-based programs to reduce tobacco use. The plan includes a public awareness campaign, cessation and nicotine addiction treatment, programs for diverse or special populations, enforcement of laws to reduce minors' access, surveillance and evaluation, and statewide program administration. The plan requests $20.75 million for fiscal year 2000 and $61.25 million for fiscal year 2001 to implement, evaluate, and administer the programs proposed.

In the fall of 1999, the Texas legislature created an endowment fund of $200 million and requested the Texas Department of Health to conduct a pilot study based upon recommended interventions included in the 1998 tobacco task force plan. This pilot would be funded by investment revenue from the endowment fund, approximately $9 million per year. In response to this requirement, the Texas Department of Health has begun an Intervention Effectiveness Pilot Study in conjunction with universities in the state.

To assess the impact of tobacco use prevention activities in the state, the Texas Department of Health has conducted the Texas Youth Tobacco Survey in 1998 and 1999 among middle and high school students from a sample of students statewide and in eight regions of the state. Results from the 1998 survey indicated 31 percent of middle school students and 43 percent of high school students were currently using some form of tobacco products (Texas Department of Health). For cigarettes alone, 21 percent of middle school students and 33 percent of high school students were current smokers.

Minnesota Settlement Program

In Minnesota, the Minnesota Partnership for Action Against Tobacco, the Tobacco Work Group of the Minnesota Health Improvement Partnership, and the Minnesota Blue Cross and Blue Shield (which received a separate $469-million settlement award [see "Recovery Claims by Third-Party Health Care Payers" in Chapter 5]) all have developed plans for the statewide effort to reduce tobacco use. In the 1999 Omnibus Health and Human Services appropriation bill, the Minnesota legislature set aside $968 million from the state's tobacco settlement to establish two health-related endowments: one for preventing tobacco use and supporting local public health efforts ($590 million) and the other for tobacco-related medical education and research ($378 million). The interest earned from these endowments will support long-term programs.

The 1999 Minnesota Omnibus Health and Human Services bill established an ambitious goal to reduce tobacco use among young people by 30 percent by the year 2005. In response to this, the Minnesota Department of Health developed the *Minnesota Youth Tobacco Prevention Initiative: Strategic Plan* (Minnesota Department of Health 1999). This plan defined major activities that will be funded from January 1, 2000, through June 30, 2001, in four component areas: Statewide Public Information and Education Campaign, Statewide Programs, Community-Based Prevention Programs, and Youth Leadership Projects. The strategic plan established "initial indicators of success" for each program component to enable program performance to be assessed.

The Statewide Public Information and Education Campaign will have a proposed budget of $7 5

million for the 18-month period. The campaign will include both a media component and grassroots organizing efforts focused on the target audience of 12- to 17-year-old youth. The Statewide Programs will be budgeted at $3.55 million for the initial 18-month period. Evaluation activities, training, and technical assistance services will be funded along with statewide organizations to support the community-based efforts. The Community-Based Prevention Programs will be budgeted at $4.4 million for the initial 18-month period. Community-based prevention efforts will include tobacco-use prevention activities at the local level and projects that focus on populations at risk. Finally, the Youth Leadership Projects will be budgeted at $1 million for the initial 18-month period and will work in conjunction with the community-based prevention efforts. These activities will seek to empower Minnesota's youth to take leadership in the planning and implementation of tobacco prevention and control programs at the local level. The Minnesota Department of Health has established an evaluation plan to track progress of the initiative, with the first comprehensive report on program effectiveness to be delivered to the legislature in January 2003.

Programs Meeting the Needs of Special Populations

The recent Surgeon General's report *Tobacco Use Among U.S. Racial/Ethnic Minority Groups* provided a summary of the various approaches that have been used to prevent and control tobacco use among racial/ethnic minority groups in the United States (USDHHS 1998). This report highlighted the need for more research on the effect of culturally appropriate programs to address this problem. Few new findings have emerged since the publication of that report; hence, the elimination of disparities in health among population groups remains hampered by the lack of culturally appropriate programs of proven efficacy. Below are some examples of community-based interventions that have proven to be effective and that may serve as examples for the development of future program initiatives.

Uniting and mobilizing the movement to reduce tobacco use among racial/ethnic groups have not been easy. Tension frequently occurs between various organizations within the community regarding appropriate strategies to achieve particular goals, "turf" disagreements, competition for fund-raising dollars, and other issues. Many of these problems were identified during the 1989–1992 COMMIT trial. Though COMMIT researchers did not attribute to internal dissension the program's inability to reach its goals (Thompson et al 1993), internecine rivalry can splinter community mobilization efforts and greatly impair the effectiveness of any program trying to reduce tobacco use.

Diverse views and dissent are an expected part of organizing activity. A more serious issue for community mobilization has been a lag in engendering support from all segments of society. Historically, the movement to reduce tobacco use has been dominated by organizations composed of middle- and upper-class white Americans and often led by white males (see Chapter 2). For many years, participation in the movement was further limited to organizations concerned with health and medical issues and nonsmokers' rights.

In the early 1980s, increasing dissatisfaction was voiced by women and underrepresented communities who felt that their issues and contributions were not adequately integrated into mainstream efforts to reduce tobacco use (Jacobson 1983). In recent years, a number of persons and organizations representing more diverse perspectives have assumed a greater role (see the text boxes "Uptown," "X," and "Dakota"). Particularly in view of the tobacco industry's targeted marketing to women, African Americans, Hispanics, and young people (USDHHS 1994, 1998), such heightened activity is of critical importance to ensure a nonsmoking norm within diverse communities. In some instances—exemplified by the low and declining smoking prevalence among African American youth (USDHHS 1994)—such a norm may have already taken hold.

Programs for the African American Community

Several leadership groups, such as the National Black Leadership Initiative on Cancer, which is funded by the NCI, and the National Association of African Americans for Positive Imagery, funded in part by the CDC, have begun to have a voice in activities to reduce tobacco use in the African American community. For example, in 1989, a strong coalition guided community mobilization efforts to mount a successful campaign against the test-marketing of Uptown, a new brand of cigarettes targeting African Americans (see the text box "Uptown"). A similar community-organized campaign in 1995 resulted in the withdrawal of X, another new brand seemingly intended for the African American community (see the text box "X").

In 1992 and 1993, the ACS provided funds for community demonstration projects to use *Pathways to Freedom: Winning the Fight Against Tobacco*, a self-help guide for African American smokers (Robinson et al

The Master Settlement Agreement



Details of the Agreement

Although the Master Settlement Agreement between tobacco companies and the States was signed over 2 years ago, many people have questions about the details of the agreement.

- How and when was the agreement formed?
- What events preceded the agreement?
- Is the agreement binding?
- Does the agreement direct States on how their settlement funds should be spent?

> The settlement agreement contained a number of important public health provisions.

Below is an excerpt from *Reducing Tobacco Use: A Report of the Surgeon General* that addresses some of these questions.

On November 23, 1998, 11 tobacco companies executed a legal settlement with 46 states, the District of Columbia, and five commonwealths and territories. The plaintiffs had sued the tobacco industry to recoup Medicaid costs for the care of persons injured by tobacco use. The suit alleged that the companies had violated antitrust and consumer protection laws, had conspired to withhold information about adverse health effects of tobacco, had manipulated nicotine levels to maintain smoking addiction, and had conspired to withhold lower-risk products from the market.

In the settlement, the companies agreed to pay states $246 billion over 25 years. But in addition, the settlement agreement contained a number of important public health provisions. The agreement placed significant marketing restrictions on the industry by prohibiting direct advertising and promotion aimed at young people, by limiting brand name sponsorship at events that might be frequented by youth, by requiring the removal of street advertising without restrictions on counteradvertising, by placing substantial restrictions on lobbying and on the suppression of research findings, and by requiring major contributions for the industry to cessation and prevention activities. In addition, the agreement dealt with such issues as legal fees, court supervision, civil liabilities restrictions, and public disclosure. Unlike the 1997 settlement, the 1998 settlement contained no provisions regarding FDA authority.

The agreement raised a number of issues for states, but foremost among these has been the competition between tobacco control efforts and other State spending priorities. The National Governors' Association issued a policy statement that reaffirmed states' entitlement and asserted that the federal government had no legitimate claim to settlement funds. The association committed to spending a "significant portion of the settlement funds on smoking cessation programs, health care, education, and programs benefitting children" but reserved the right to make funding decisions tailored to states' individual needs. For FY2001, 35 states have appropriated $614.9 million from the settlement agreement specifically for tobacco prevention and control purposes.

REFERENCE

1. *Reducing Tobacco Use: A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services; 2000.

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Death and Disease Attributable to Tobacco Use



Deaths Due to Smoking-Related Illness

Cigarette smoking is the single most preventable cause of premature death in the United States. More than 430,000 Americans die each year from smoking-related illness.[1] One in every five U.S. deaths is smoking related.[2] The ongoing human toll from tobacco use has been documented in a number of ways:

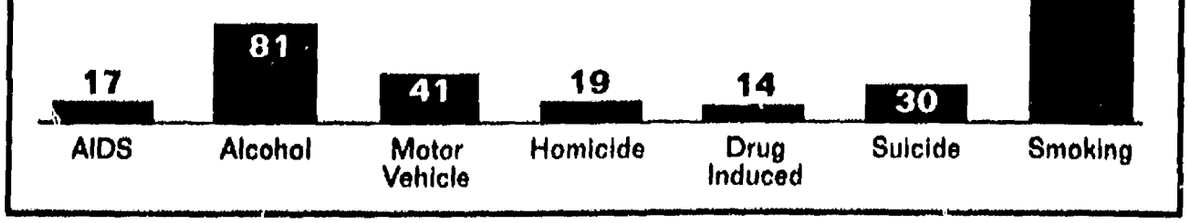
One in every five deaths in the United States is smoking related

Human Toll From Tobacco Use

- "About 10 million people in the U.S. have died from causes attributed to smoking (including heart disease, emphysema, and other respiratory diseases) since the first Surgeon General's report on smoking and health in 1964—2 million of these deaths were the result of lung cancer alone."[3]
- "Between 1960 and 1990, deaths from lung cancer among women have increased by more than 400%—exceeding breast cancer deaths in the mid-1980s."[4]
- "African Americans continue to suffer disproportionately from chronic and preventable disease compared with white Americans."[5] "Of the three leading causes of death in African Americans—heart disease, cancer, and stroke—smoking and other tobacco use are major contributors."[6]
- "Annually, exposure to environmental tobacco smoke (ETS) causes an estimated 3,000 deaths from lung cancer among American adults. Scientific studies also link secondhand smoke with heart disease."[7]
- "Infants and young children exposed to ETS experience increased rates of lower respiratory tract infections (such as bronchitis and pneumonia) and ear infections, an exacerbation of chronic respiratory symptoms (such as asthma), a reduced rate of lung growth, and an increased risk of death from SIDS."[8]

Comparative Causes of Annual Deaths in the United States[9]

(Number of Deaths in Thousands)



Source: CDC, Actual Causes of Death, United States, 1990

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REFERENCES

1. *Best Practices for Comprehensive Tobacco Control Programs—August 1999.* Atlanta, GA: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 1999.

2. Centers for Disease Control and Prevention. Smoking-attributable mortality and years of potential life lost—United States, 1990. *MMWR* 1993;42(33):645–648.

3. Centers for Disease Control and Prevention, Office on Smoking and Health. Unpublished data, 1994. Available at: http://www.cdc.gov/tobacco/research_data/health_consequences/mortali.htm. Accessed November 27, 2000.

4. Centers for Disease Control and Prevention. Mortality trends for selected smoking-related and breast cancer—United States, 1950–1990. *MMWR* 1993;42(44):857, 863–866.

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

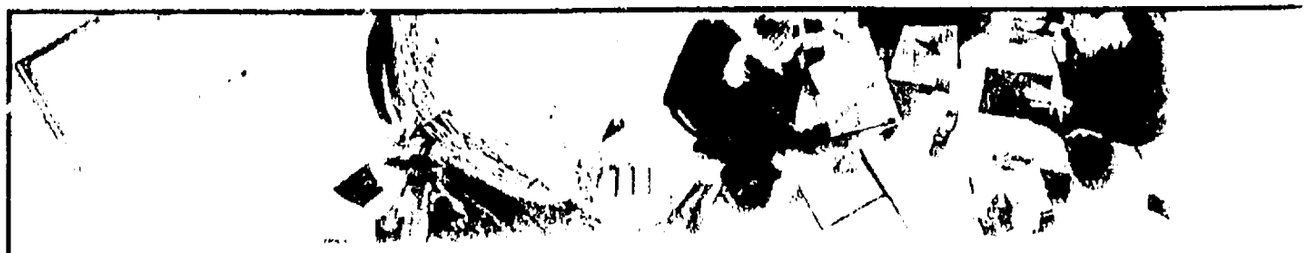
6. *Chronic Disease in Minority Populations.* Atlanta, GA: Centers for Disease Control and Prevention; 1994:2–16. Cited in: Centers for Disease Control and Prevention. African Americans and Tobacco [fact sheet]. Available at: http://www.cdc.gov/tobacco/sgr/sgr_1998/sgr-min-fs-afr.htm. Accessed November 27, 2000.

7. *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders.* Washington, DC: U.S. Environmental Protection Agency, Office of Health and Environmental Assessment, Office of Research and Development; December 1992. EPA/600/6-90/006F.

8. World Health Organization, Tobacco Free Initiative. *International Consultation on Environmental Tobacco Smoke (ETS) and Child Health, 11–14 January 1999 Geneva, Switzerland, Consultation Report.* Geneva, Switzerland: World Health Organization; 1999.

9. Centers for Disease Control and Prevention. *Targeting Tobacco Use: The Nation's Leading Cause of Death.* At-a-Glance 2000. Available at: http://www.cdc.gov/tobacco/overview/oshaag.htm. Accessed November 27, 2000.

The U.S. Economic Impact of Tobacco Use



Tobacco use, particularly cigarette smoking, accounts for a substantial and preventable portion of all U.S. health care expenditures. The Centers for Disease Control and Prevention's Office on Smoking and Health has estimated that, each year, tobacco use causes more than 430,000 deaths and costs the United States approximately $50 to $73 billion in medical expenses alone. Following are other facts on tobacco use's impact on the U.S. health care system and economy:

The most recent national estimates available place U.S. smoking-attributable costs for medical care at $50 billion in 1993; with inflation, current costs are probably higher. Of the $50 billion in 1993, $26.9 billion were for hospital expenditures, $15.5 billion for physician expenditures, $4.9 billion for nursing home expenditures, $1.8 billion for prescription drugs, and $900 million for home-health care expenditures."

Public funding (primarily Medicare and Medicaid) pays, on average, over 40 percent—or more than $20 billion—of smoking-related health care costs in the Nation each year.

Smokers with existing smoking-related diseases use services for nonsmoking-related diseases at a higher rate than nonsmokers; they also tend to need more medications and have more procedures performed. Compared with nonsmokers, smokers' health outcomes tend to be worse and their recovery periods longer for surgeries unrelated to smoking.

"In 1987, the estimated direct medical costs of a complicated birth for a smoker was 66% higher than that for nonsmokers and the medical-care expenditures attributable to smokers with complicated births was an estimated $791 million in 1987 dollars, representing 11% of the total medical expenditures for all complicated births ($7 billion)."

Smokers directly affect the health of nonsmokers. Mothers who smoke increase their infants' risk of low birthweight and various diseases. Smokers also increase the risk of disease in children and adults chronically exposed to environmental tobacco smoke.

"Other direct costs include irritation and nuisance from smoke and the cost of cleaning clothes and furnishings. There may also be a cost from fires, environmental degradation, and deforestation from tobacco growing and processing, and from the consequences of smoking."

"For policymakers, it is vital to know these annual healthcare costs and the fraction borne by the public sector, because they represent real resources that cannot be used for other goods and services."

REFERENCES

1. *Best Practices for Comprehensive Tobacco Control Programs—August 1999.* Atlanta, GA: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 1999.

2. Centers for Disease Control and Prevention. Medical care expenditures attributable to cigarette smoking—United States, 1993. *MMWR* 1994;43(26):469.

3. U.S. Department of the Treasury. *The Economic Costs of Smoking in the United States and the Benefits of Comprehensive Tobacco Legislation.* Available at: www.treas.gov/press/releases/docs/tobacco/pdf. Accessed November 22, 2000.

4. Warner KE, Hodgson TA, Carroll CE. Medical costs of smoking in the United States: Estimates, their validity, and their implications. *Tobacco Control* 1999;8:290–300.

5. The World Bank Group. *Curbing the Epidemic: Governments and the Economics of Tobacco Control.* Washington, DC: The World Bank; 1999. Available at: www1.worldbank.org/tobacco/reports.htm. Accessed November 21, 2000.

Public Support for Tobacco Control



The American public's support of tobacco control can be seen not only in the shifting norms on tobacco use, but in a number of surveys:

National Support

- A study by the Centers for Disease Control and Prevention found broad support for a total ban on the use of any tobacco product (including cigarettes, cigars, pipes, and chewing tobacco) at school-sponsored events.[1]

- The same study found that most respondents believed that stronger enforcement of laws prohibiting the sale of cigarettes to minors would be effective in keeping teenagers from smoking.[1]

> 73 percent of the bar patrons surveyed said they approve of the law that prohibits smoking in bars

Regional Support

- In a study conducted in four states, approximately 65 percent of the respondents would support an extra tax on tobacco to finance public campaigns against smoking. More than 82 percent believed that stronger laws should be enacted to prevent the sale of tobacco products to minors, and more than 86 percent believed that existing laws should be better enforced.[2]

- According to an Oregon Smokeless States survey, 77 percent of the Oregon citizens responding believe that local communities should be in control of the laws that affect the health of their citizens; 78 percent believe that local communities should have the power to pass laws protecting people from secondhand smoke in public places; and 85 percent said that people should be protected from secondhand smoke.[3]

- In a poll conducted in California, 73 percent of the bar patrons surveyed said they approve of the law that prohibits smoking in bars, a 24 percent increase from the rate in 1998 when the law took effect.[4]

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REFERENCES

1. Centers for Disease Control and Prevention. Attitudes toward smoking policies in eight states—United States, 1993. *MMWR* 1994;43(43):786–789.

2. Marcus SE, Emont SL, Corcoran RD, Giovino GA, Pierce JP, Waller MN, Davis RM. Public attitudes about cigarette smoking: Results from the 1990 Smoking Activity Volunteer Executed Survey. *Public Health Rep* 1994;109(1):125–134.

3. Oregon Health Division, Tobacco Prevention ano Education Program. *Oregon Public Opinion Polls: Secondhand Smoke Protection.* Available at: www.ohd.hr.state.or.us/tobacco/people/shspro.htm. Accessed November 27, 2000.

4. California Department of Health Services, Office of Public Affairs. *Support for smoke-free bars grows stronger in California;* October 16, 2000. Available at: www.dhs.ca.gov/opa/prssrels/2000/56-00.htm. Accessed November 27, 2000.

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Comprehensive State Tobacco Control Programs



Reducing Tobacco Use

According to the U.S. Surgeon General, State tobacco control programs "have emerged as the new laboratory for developing and evaluating comprehensive plans to reduce tobacco use. State tobacco programs, funded by excise taxes on tobacco products and settlements with the tobacco industry, have produced early, encouraging evidence of the efficacy of the comprehensive approach to reducing tobacco use." The Institute of Medicine has concurred, finding that "multifaceted state tobacco control programs are effective in reducing tobacco use."

The Centers for Disease Control and Prevention's Office on Smoking and Health (CDC-OSH) recommends four goals in its framework for State tobacco control programs:

- Prevent the initiation of tobacco use among young people
- Promote quitting among adults and young people
- Eliminate exposure to environmental tobacco smoke (ETS)
- Identify and eliminate health disparities among population groups

In a nationwide poll, 84% of the respondents favored spending the money their State receives to reduce tobacco use among kids

Nine Components to Success

CDC-OSH has outlined nine components that are essential to a successful, comprehensive tobacco control program:

1. **Community tobacco prevention programs** that engage youth, develop partnerships, educate communities, and promote government and voluntary tobacco control policies
2. **Chronic disease programs** to reduce the burden of tobacco-related disease, including cardiovascular-disease and asthma prevention programs, oral health programs, and cancer registries
3. **School prevention programs** that are evidence based and include teacher training, parental participation, tobacco-free policies, and cessation services; they should also be linked with community and State programs
4. **Enforcement of tobacco control policies**, especially those that restrict minors' access to tobacco and smoking in public places
5. **Statewide programs** that provide technical assistance to local programs on evaluation, media advocacy, tobacco control policies, and reducing racial/ethnic health disparities
6. **Counter-marketing** to counter pro-tobacco influences and increase pro-health messages through a variety of media
7. **Smoking cessation programs**
8. **A surveillance and evaluation system** to help State policymakers and others responsible for fiscal oversight monitor the program
9. **A strong administrative and managerial system** to coordinate the program's components and partnerships with government agencies, voluntary organizations, and community groups

Because there are a number of factors—cultural, familial, social, economic—that affect people's decisions to start or stop using tobacco, "programs to reduce tobacco use will be most effective if they address all the components that may influence the individual's behavior choices."

CDC

HEALTHIER PEOPLE

www.cdc.gov/tobacco

REFERENCES

1. *Reducing Tobacco Use: A Report of the Surgeon General.* Atlanta, GA: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2000.

2. Institute of Medicine. *State Programs Can Reduce Tobacco Use. A Report of the National Cancer Policy Board.* Washington, DC: National Research Council; 2000.

3. *Best Practices for Comprehensive Tobacco Control Programs—August 1999.* Atlanta, GA: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 1999.

4. Polling data from Mason Dixon Political/Media Research, October 1998.

CDC

SAVING HEALTHIER PEOPLE

www.cdc.gov/tobacco

Bruce Levi

Testimony on Engrossed SB 2380
Senate Appropriations Committee
February 19, 2001

The North Dakota Medical Association supports the forward steps represented by Engrossed SB 2380 in establishing a mechanism within the ND Health Department for developing an adequately funded, comprehensive tobacco prevention and treatment dependency program in our state. Tobacco use is the single most preventable cause of death in the United States and in North Dakota. Not only would a comprehensive program diminish the individual family tragedies associated with tobacco-related disease and death, but would also help stem the rising cost of health care for families and businesses in North Dakota.

The evidence shows that multi-faceted, state-based tobacco control programs are effective in reducing tobacco use. However, the evidence shows that those programs must also be adequately funded to be effective. The Centers for Disease Control and Prevention recommends in *Best Practices for Comprehensive Tobacco Control Programs*, August 1999, that North Dakota fund annual allocations for each program component as follows, with comparison to the biennial allocations proposed in Governor Hoeven's plan and Engrossed SB 2380:

	CDC Upper Estimate (Annual Est.)	CDC Lower Estimate (Annual Est.)	Governor's Plan (Biennium)	Eng SB 2380 (Biennium)
Community Programs to Reduce Tobacco Use	$2,482,000	$1,299,000		$2,000,000
Chronic Disease Programs to Reduce The Burden of Tobacco-Related Diseases	$4,162,000	$2,787,000		
School Programs	$1,498,000	$ 999,000		$2,000,000
Cessation Programs	$2,865,000	$ 687,000		
Subtotal	**$11,007,000**	**$5,772,000**	**$5,753,799**[1]	**$4,000,000**
Enforcement	$ 817,000	$ 426,000		
Statewide Programs	$ 641,000	$ 257,000	$ 220,332	$ 250,000[2]
Counter-Marketing	$1,923,000	$ 641,000	$ 549,453	$ 750,000
Surveillance and Evaluation	$1,439,000	$ 710,000	$ 608,668	
Administration and Management	$ 720,000	$ 355,000	$ 237,682	
Unknown				$ 100,000
Totals	**$16,547,000**	**$8,161,000**	**$7,369,934**	**$5,100,000**[3]
Per capita	$25.82	$12.73	approx. $5	

[1] Governor Hoeven's Plan provides $5,753,799 for the 2001-03 biennium for community programs that include chronic disease programs, school programs and cessation programs.
[2] Engrossed SB 2380 includes $250,000 to provide "antitobacco materials and resources to the public."
[3] Engrossed SB 2380 includes an unspecified amount that represents the receipt of federal funds. Currently, North Dakota receives $1,099,997 annually from the CDC to the Health Department for a state tobacco prevention and control program.

Proposed Amendments: Using the CDC *Best Practices* as guidance as to minimum recommendations for an effective tobacco prevention program, the Medical Association proposes three alternative amendments to Engrossed SB 2380, which suggest various approaches for allocating additional funds to the tobacco prevention program.

The first proposed amendments (Alternative 1) would appropriate the entire $7,600,000 to the tobacco prevention fund for use during the 2001-2003 biennium for implementing the state plan for tobacco prevention and dependency treatment. For future bienniums, the proposed amendments would allocate one-third of the tobacco settlement funds for the tobacco prevention fund and allocate the interest from the community health trust fund to the tobacco prevention fund, subject to future appropriations.

The second proposed amendments (Alternative 2) would also appropriate the entire $7,600,000 to the tobacco prevention fund for use during the 2001-2003 biennium for implementing the state plan for tobacco prevention and dependency treatment. In addition, the proposed amendments would increase the funds available during the 2001-03 biennium for a comprehensive tobacco prevention program by increasing the tax on cigarettes. The proposed amendments would also allocate the interest from the community health trust fund to the tobacco prevention fund, subject to future appropriations. These amendments, coupled with the existing funds available in the trust fund and federal funds, would provide an appropriation of $12.6 million during the 2001-03 biennium for the comprehensive program.

The third proposed amendments (Alternative 3) would also appropriate the entire $7,600,000 to the tobacco prevention fund for use during the 2001-2003 biennium for implementing the state plan for tobacco prevention and dependency treatment. However, these proposed amendments would not allocate funds for future bienniums for tobacco prevention, with the exception of allocating the interest from the community health trust fund to the tobacco prevention fund.

North Dakota physicians support the development of an adequately funded, comprehensive tobacco prevention and dependency treatment program.

Last fall, North Dakota's physicians through NDMA's House of Delegates adopted a resolution supporting the development in North Dakota of a science-based, comprehensive tobacco prevention and dependence treatment program, using one-third of the tobacco settlement funds for this purpose.

In coming to that conclusion, physicians relied on the following points:

The use of tobacco products by North Dakota citizens has resulted in devastating health and economic consequences, including 1050 deaths each year, and healthcare expenditures of over $180 million (over 11% of all health care expenditures in North Dakota) -- the burden being imposed on taxpayers, businesses, individuals, and government.

Tobacco companies spend $12 million annually advertising their products in North Dakota, influencing more than 22% of our citizens to smoke and chew tobacco and giving our state the third worst national ranking in per capita death rate, as well as the third highest youth smoking rate in the nation.

Primary care physicians in North Dakota are in the unique position of seeing the tragic effects of smoking and second-hand smoke in their patients on a daily basis, including cases of heart disease, lung cancer, emphysema, bronchitis, pneumonia, sinusitis, and ear infections in both adults and children.

The North Dakota Chapters of the American Academy of Family Physicians, the American Academy of Pediatrics, and the American College of Physicians – American Society of Internal Medicine have each given their support to a strong tobacco education and prevention program in North Dakota.

The U.S. Centers for Disease Control has developed a science-based approach to tobacco prevention and cessation illustrating "best practices" strategies and programs to be implemented on a state-wide basis, including community programs to reduce tobacco use, chronic disease programs, school programs, enforcement efforts, statewide programs, countermarketing, and cessation programs.

Research shows that these best practice strategies are most effective when they are all integrated into a comprehensive program. The experience in other states with comprehensive programs such as Massachusetts, California, Oregon and Florida shows that, when adequately funded, these comprehensive programs can quickly and substantially reduce tobacco use.

Engrossed SB 2380 would take steps to begin development in North Dakota of a *comprehensive* approach to tobacco prevention and dependency treatment. However, while the language in Engrossed SB 2380 supports a comprehensive approach (p. 4, lines 13 through 20), the specific allocation of funds (p. 7, lines 3 through 24) in the bill is not entirely consistent with a comprehensive approach.

Scientific knowledge and strategies exist to reduce tobacco use, and can serve as the foundation for action in North Dakota

The Surgeon General of the United States, as well as the Centers for Disease Control and Prevention, have documented evidence showing that multi-faceted, state-based tobacco control programs are effective in reducing tobacco use. The Surgeon General's 2000 report: *Reducing Tobacco Use* provides an in-depth review of the effectiveness of tobacco intervention strategies. The evidence reviewed in the report shows that comprehensive state tobacco control programs are effective in reducing tobacco use because they bring about a shift in social norms and reduce the broad cultural acceptability of tobacco use. According to the Surgeon General's report, the components of a multi-faceted approach include: (1) community interventions, which include diverse entities such as schools, health agencies, city and county governments, and civic, social, and recreation organizations, (2) countermarketing, which includes using media advocacy, paid media, prohealth promotions, and other media strategies to change social norms regarding tobacco use, (3) program policy and regulation, which addresses such issues as minors' access, tobacco pricing, advertising and promotion, clean indoor air, product regulation, and tobacco use cessation, and (4) surveillance and evaluation, which includes monitoring tobacco industry promotional campaigns, evaluating the economic impact of environmental tobacco smoke (ETS) laws and policies, conducting surveys of public opinion on program interventions, and other activities to make ongoing refinements that lead to more effective prevention strategies.

The Surgeon General's report cites the following major conclusions:

•Efforts to prevent the onset or continuance of tobacco use face the pervasive, countervailing influence of tobacco promotion that takes place despite overwhelming evidence of adverse health effects from tobacco use.

• The available approaches to reducing tobacco use - educational, clinical, regulatory, economic, and comprehensive - differ substantially in their techniques and in the metric by which success can be measured. A hierarchy of effectiveness is difficult to construct.

•Approaches with the largest span of impact (economic, regulatory, and comprehensive) are likely to have the greatest long-term, population impact. Those with a smaller span of impact (educational and clinical) are of greater importance in helping individuals resist or abandon the use of tobacco.

•Each of the modalities reviewed provides evidence of effectiveness.

- Educational strategies, conducted in conjunction with community- and media-based activities, can postpone or prevent smoking onset in 20 to 40 percent of adolescents.
- Pharmacologic treatment of nicotine addiction, combined with behavioral support, will enable 20 to 25 percent of users to remain abstinent at one year posttreatment. Even less intense measures, such as physicians advising their patients to quit smoking, can produce cessation proportions of 5 to 10 percent.
- Regulation of advertising and promotion, particularly that directed at young people, is very likely to reduce both prevalence and uptake of tobacco use.
- Clean air regulations and restriction of minors' access to tobacco products contribute to a changing social norm with regard to smoking, and may influence prevalence directly.
- An optimal level of of excise taxation on tobacco products will reduce the prevalence of smoking, the consumption of tobacco, and the long-term health consequences of tobacco use.

•The impact of these various efforts, as measured with a variety of techniques, is likely to be underestimated because of the synergistic effect of these modalities. The potential for combined effects underscores the need for comprehensive approaches.

•State tobacco control programs, funded by excise taxes on tobacco products and settlements with the tobacco industry, have produced early, encouraging evidence of the efficacy of the comprehensive approach to reducing tobacco use.

The Surgeon General's report notes that the synergy created by the interaction of various program components in a comprehensive approach is believed to be responsible for increased success in reducing tobacco use. The report states, in addressing the need for comprehensive approaches:

> The evidence of effectiveness summarized in this report emphasizes that public health success in reducing tobacco use requires activity using multiple modalities. A comprehensive approach - one that optimizes synergy from applying a mix of educational, clinical, regulatory, economic, and social strategies - has emerged as the guiding principle for future efforts to reduce tobacco use. The public health goals of such comprehensive programs are to reduce disease, disability, and death related to tobacco use through prevention and cessation, as well as through protection of the nonsmoker from ETS.
>
> The emerging body of data on statewide tobacco control efforts is coming from programs broadly focused on prevention, cessation, and protection of the nonsmoker from ETS. Preventing initiation among young people is a primary goal of any tobacco control effort. However, young people will

perceive contradictory or inconsistent messages in our prevention efforts if programs do not also address the smoking behavior of millions of parents and other adult role models and the public health risks of ETS.

Attached to this testimony are copies of relevant portions of the 2000 Surgeon General's Report, *Reducing Tobacco Use*, which also includes specific descriptions of major programs developed in Minnesota, California, Massachusetts, Arizona, Oregon, Maine, Mississippi, Florida, and Texas. Also included is a report generated from a panel convened by the former Attorney General, in an effort that involved a number of physicians in identifying a comprehensive, science-based approach to tobacco prevention and dependency treatment in North Dakota. We urge you to review the documents, which describe the components and merits of a comprehensive approach to reducing tobacco use in North Dakota.

The North Dakota Medical Association stands ready to provide information and technical assistance from physicians if necessary to assist the committee. We urge the Committee to consider the proposed amendments to Engrossed SB 2380.

PROPOSED AMENDMENTS TO ENGROSSED SB 2380

Page 1, line 2, remove "subsection 1 of"

Page 2, line 27, remove "members of"

Page 3, line 22, replace "appropriation" with "appropriations"

Page 4, line 24, after "prevention" insert "and dependency treatment"

Page 5, line 12, after "prevention" insert "and dependency treatment"

Page 6, replace lines 27 through 31 with :

"**SECTION 10. AMENDMENT.** Section 54-27-25 of the 1999 Supplement to the North Dakota Century Code is amended and reenacted as follows:

54-27-25. Tobacco settlement trust fund - Interest on fund - Uses. There is created in the state treasury a tobacco settlement trust fund. The fund consists of the tobacco settlement dollars obtained by the state under sections IX (payments) and XI (calculation and disbursement of payments) of the master settlement agreement and consent agreement adopted by the east central judicial district court in its judgment entered December 28, 1998 [Civil No. 98-3778]. All moneys received by the state pursuant to the judgment and all moneys received by the state for enforcement of the judgment must be deposited in the fund. Interest earned on the fund must be credited to the fund and deposited in the fund. After the effective date of this Act, one-third of the principal and all interest on the funds deposited in the tobacco settlement trust fund must be deposited in the state tobacco prevention fund created by section 5 of this Act. The remaining principal and interest of the tobacco settlement trust fund must be allocated as follows:

1. Transfers to a community health trust fund to be administered by the state department of health. The state department of health may use funds as appropriated for community-based public health programs and other public health programs, ~~including programs with emphasis on preventing or reducing tobacco usage in this state~~. Transfers under this subsection must equal ten percent of total annual transfers from the tobacco settlement trust fund, less amounts transferred to the tobacco prevention fund. All interest earned on moneys in the community health trust fund must be deposited in the tobacco prevention fund created under section 5 of this Act.
2. Transfers to the common schools trust fund to become a part of the principal of that fund. Transfers under this subsection must equal forty-five percent of total annual transfers from the tobacco settlement trust fund, less amounts transferred to the tobacco prevention fund.
3. Transfers to the water development trust fund to be used to address the long-term water development and management needs of the state. Transfers under this subsection must equal forty-five percent of the total annual transfers from the tobacco settlement trust fund, less amounts transferred to the tobacco prevention fund.

Notwithstanding the provisions of this section, during each biennium transfers that would be made to the common schools trust fund under subsection 2 must instead be transferred to the

water development trust fund until the state water commission certifies to the state treasurer that deposits in the water development trust fund during that biennium are sufficient to pay the principal and interest for that biennium on bonds authorized under section 61-02.1-01. When that certification is received, the state treasurer shall determine the amount deposited in the water development trust fund during that biennium and transfers that would be made to the water development trust fund under subsection 3 must instead be transferred to the common schools trust fund until deposits in the common schools trust fund during that biennium are equal to the amount deposited in the water development trust fund during that biennium or until the end of the biennium, whichever occurs first.

Transfers to the funds under this section must be made within thirty days of receipt by the tobacco settlement trust fund."

Page 7, remove lines 1 through 24
Page 7, line 28, after the first "the" insert "tobacco prevention fund for use by the"

Renumber accordingly

ND Medical Association
Alternative 2

PROPOSED AMENDMENTS TO ENGROSSED SB 2380

Page 1, line 2, after "54-27-25" insert "and section 57-36-32"
Page 1, line 3, after "fund" insert "and the rate of tax on the sale of cigarettes"

Page 2, line 27, remove "members of"

Page 3, line 22, replace "appropriation" with "appropriations"

Page 4, line 24, after "prevention" insert "and dependency treatment"

Page 5, line 12, after "prevention" insert "and dependency treatment"

Page 6, line 30, remove the overstrike over "~~The state department of health may use funds as~~"
Page 6, line 31, remove the overstrike over "~~appropriated for~~"

Page 7, line 2, after "~~state~~" insert "the purpose of implementing the tobacco prevention and dependency treatment plan established pursuant to section 6 of this Act" and remove the overstrike over the overstruck period
Page 7, line 3, replace "Of the funds appropriated" with "All interest earned on moneys in the community health trust fund must be deposited in the tobacco prevention fund created under section 5 of this Act."
Page 7, replace lines 4 through 24 with:

"**SECTION 11. AMENDMENT.** Section 57-36-32 of the North Dakota Century Code is amended and reenacted as follows:

57-36-32. Separate and additional tax on the sale of cigarettes - Collection – Allocation of revenue - Tax avoidance prohibited. There is hereby levied and assessed and there shall be collected by the state tax commissioner and paid to the state treasurer, upon all cigarettes sold in this state, an additional tax, separate and apart from all other taxes, of ~~seventeen~~ twenty-two mills on each cigarette, to be collected as existing taxes on cigarettes sold are, or hereafter may be, collected, by use of appropriate stamps and under similar accounting procedures. No person, firm, corporation, or limited liability company shall transport or bring or cause to be shipped into the state of North Dakota any cigarettes as provided herein, other than for delivery to wholesalers in this state, without first paying the tax thereon to the state tax commissioner. All of the moneys collected by the state treasurer under this section shall be credited to the state general fund, except the net revenue from five mills per cigarette of the tax imposed under this section must be deposited in the tobacco prevention fund created under section 5 of this Act."

Page 7, line 27, replace "$7,600,000" with "$12,600,000"
Page 7, line 28, after the first "the" insert "tobacco prevention fund for use by the"

Renumber accordingly

ND Medical Association
Alternative 3

PROPOSED AMENDMENTS TO ENGROSSED SB 2380

Page 2, line 27, remove "members of"

Page 3, line 22, replace "appropriation" with "appropriations"

Page 4, line 24, after "prevention" insert "and dependency treatment"

Page 5, line 12, after "prevention" insert "and dependency treatment"

Page 6, line 30, remove the overstrike over "~~The state department of health may use funds as~~"
Page 6, line 31, remove the overstrike over "~~appropriated for~~"

Page 7, line 2, after "~~state~~" insert "the purpose of implementing the tobacco prevention and dependency treatment plan established pursuant to section 6 of this Act" and remove the overstrike over the overstruck period
Page 7, line 3, replace "Of the funds appropriated" with "All interest earned on moneys in the community health trust fund must be deposited in the tobacco prevention fund created under section 5 of this Act."
Page 7, remove lines 4 through 24
Page 7, line 28, after the first "the" insert "tobacco prevention fund for use by the"

Renumber accordingly

Testimony on Reengrossed SB 2380
House Human Services Committee
March 6, 2001

The North Dakota Medical Association supports the forward steps represented by Reengrossed SB 2380 in establishing a mechanism within the ND Health Department for developing an adequately funded, comprehensive tobacco prevention and treatment dependency program in our state.

Tobacco use is the single most preventable cause of death in the United States and in North Dakota. Not only would a comprehensive program diminish the individual family tragedies associated with tobacco-related disease and death, but would also help stem the rising cost of health care for families and businesses in North Dakota.

North Dakota physicians support the development of an adequately funded, comprehensive tobacco prevention and dependency treatment program.

Last fall, North Dakota's physicians through NDMA's House of Delegates adopted a resolution supporting the development in North Dakota of a science-based, comprehensive tobacco prevention and dependence treatment program, using one-third of the tobacco settlement funds for this purpose.

In coming to that conclusion, physicians relied on the following points:

The use of tobacco products by North Dakota citizens has resulted in devastating health and economic consequences, including 1050 deaths each year, and healthcare expenditures of over $180 million (over 11% of all health care expenditures in North Dakota) -- the burden being imposed on taxpayers, businesses, individuals, and government.

Tobacco companies spend $12 million annually advertising their products in North Dakota, influencing more than 22% of our citizens to smoke and chew tobacco and giving our state the third worst national ranking in per capita death rate, as well as the third highest youth smoking rate in the nation.

Primary care physicians in North Dakota are in the unique position of seeing the tragic effects of smoking and second-hand smoke in their patients on a daily basis, including cases of heart disease, lung cancer, emphysema, bronchitis, pneumonia, sinusitis, and ear infections in both adults and children.

The North Dakota Chapters of the American Academy of Family Physicians, the American Academy of Pediatrics, and the American College of Physicians – American Society of Internal Medicine have each given their support to a strong tobacco education and prevention program in North Dakota.

The U.S. Centers for Disease Control has developed a science-based approach to tobacco prevention and cessation illustrating "best practices" strategies and programs to be implemented on a state-wide basis, including community programs to reduce tobacco use, chronic disease programs, school programs, enforcement efforts, statewide programs, countermarketing, and cessation programs.

Research shows that these best practice strategies are most effective when they are all integrated into a comprehensive program. The experience in other states with comprehensive programs such as

Massachusetts, California, Oregon and Florida shows that, when adequately funded, these comprehensive programs can quickly and substantially reduce tobacco use.

Reengrossed SB 2380 would take steps to begin development in North Dakota of a *comprehensive* approach to tobacco prevention and dependency treatment.

Scientific knowledge and strategies exist to reduce tobacco use, and can serve as the foundation for action in North Dakota

The Surgeon General of the United States, as well as the Centers for Disease Control and Prevention, have documented evidence showing that multi-faceted, state-based tobacco control programs are effective in reducing tobacco use. The Surgeon General's 2000 report: *Reducing Tobacco Use* provides an in-depth review of the effectiveness of tobacco intervention strategies. The evidence reviewed in the report shows that comprehensive state tobacco control programs are effective in reducing tobacco use because they bring about a shift in social norms and reduce the broad cultural acceptability of tobacco use. According to the Surgeon General's report, the components of a multi-faceted approach include: (1) community interventions, which include diverse entities such as schools, health agencies, city and county governments, and civic, social, and recreation organizations, (2) countermarketing, which includes using media advocacy, paid media, prohealth promotions, and other media strategies to change social norms regarding tobacco use, (3) program policy and regulation, which addresses such issues as minors' access, tobacco pricing, advertising and promotion, clean indoor air, product regulation, and tobacco use cessation, and (4) surveillance and evaluation, which includes monitoring tobacco industry promotional campaigns, evaluating the economic impact of environmental tobacco smoke (ETS) laws and policies, conducting surveys of public opinion on program interventions, and other activities to make ongoing refinements that lead to more effective prevention strategies.

The Surgeon General's report cites the following major conclusions:

•Efforts to prevent the onset or continuance of tobacco use face the pervasive, countervailing influence of tobacco promotion that takes place despite overwhelming evidence of adverse health effects from tobacco use.

•The available approaches to reducing tobacco use – educational, clinical, regulatory, economic, and comprehensive – differ substantially in their techniques and in the metric by which success can be measured. A hierarchy of effectiveness is difficult to construct.

•Approaches with the largest span of impact (economic, regulatory, and comprehensive) are likely to have the greatest long-term, population impact. Those with a smaller span of impact (educational and clinical) are of greater importance in helping individuals resist or abandon the use of tobacco.

•Each of the modalities reviewed provides evidence of effectiveness.
- Educational strategies, conducted in conjunction with community- and media-based activities, can postpone or prevent smoking onset in 20 to 40 percent of adolescents.
- Pharmacologic treatment of nicotine addiction, combined with behavioral support, will enable 20 to 25 percent of users to remain abstinent at one year posttreatment. Even less intense measures, such as physicians advising their patients to quit smoking, can produce cessation proportions of 5 to 10 percent.
- Regulation of advertising and promotion, particularly that directed at young people, is very likely to reduce both prevalence and uptake of tobacco use.

- Clean air regulations and restriction of minors' access to tobacco products contribute to a changing social norm with regard to smoking, and may influence prevalence directly.
- An optimal level of of excise taxation on tobacco products will reduce the prevalence of smoking, the consumption of tobacco, and the long-term health consequences of tobacco use

•The impact of these various efforts, as measured with a variety of techniques, is likely to be underestimated because of the synergistic effect of these modalities. The potential for combined effects underscores the need for comprehensive approaches.

•State tobacco control programs, funded by excise taxes on tobacco products and settlements with the tobacco industry, have produced early, encouraging evidence of the efficacy of the comprehensive approach to reducing tobacco use.

The Surgeon General's report notes that the synergy created by the interaction of various program components in a comprehensive approach is believed to be responsible for increased success in reducing tobacco use. The report states, in addressing the need for comprehensive approaches:

> The evidence of effectiveness summarized in this report emphasizes that public health success in reducing tobacco use requires activity using multiple modalities. A comprehensive approach – one that optimizes synergy from applying a mix of educational, clinical, regulatory, economic, and social strategies – has emerged as the guiding principle for future efforts to reduce tobacco use. The public health goals of such comprehensive programs are to reduce disease, disability, and death related to tobacco use through prevention and cessation, as well as through protection of the nonsmoker from ETS.

> The emerging body of data on statewide tobacco control efforts is coming from programs broadly focused on prevention, cessation, and protection of the nonsmoker from ETS. Preventing initiation among young people is a primary goal of any tobacco control effort. However, young people will perceive contradictory or inconsistent messages in our prevention efforts if programs do not also address the smoking behavior of millions of parents and other adult role models and the public health risks of ETS.

Attached to this testimony are copies of relevant portions of the 2000 Surgeon General's Report, *Reducing Tobacco Use*, which also includes specific descriptions of major programs developed in Minnesota, California, Massachusetts, Arizona, Oregon, Maine, Mississippi, Florida, and Texas. Also attached is a recent CDC publication, *Investment in Tobacco Control: State Highlights 2001*, which describes activities of states to reduce tobacco use and provides an executive summary of the *CDC Best Practices for Comprehensive Tobacco Control Programs*. Also included is a report generated from a panel convened by the former Attorney General, in an effort that involved a number of physicians in identifying a comprehensive, science-based approach to tobacco prevention and dependency treatment in North Dakota. We urge you to review all these important documents, which describe the components and merits of a comprehensive approach to reducing tobacco use in North Dakota.

The evidence shows that multi-faceted, state-based tobacco control programs are effective in reducing tobacco use. However, the evidence shows that those programs must also be adequately funded to be effective.

The Centers for Disease Control and Prevention recommends in *Best Practices for Comprehensive Tobacco Control Programs*, August 1999, that North Dakota fund annual allocations for each program component as follows, with comparison to the biennial allocations proposed in Governor Hoeven's plan and Reengrossed SB 2380 and Engrossed SB 2004:

	CDC Upper Estimate (Annual Est.)	CDC Lower Estimate (Annual Est.)	Governor's Plan (Biennium)	SB 2380 2004 (Biennium)
Community Programs to Reduce Tobacco Use	$2,482,000	$1,299,000		
Chronic Disease Programs to Reduce The Burden of Tobacco-Related Diseases	$4,162,000	$2,787,000		
School Programs	$1,498,000	$ 999,000		
Cessation Programs	$2,865,000	$ 687,000		
Subtotal	**$11,007,000**	**$5,772,000**	**$5,753,799**[1]	**$4,000,000**[2]
Enforcement	$ 817,000	$ 426,000		
Statewide Programs	$ 641,000	$ 257,000	$ 220,332	
Counter-Marketing	$1,923,000	$ 641,000	$ 549,453	$1,000,000
Surveillance and Evaluation	$1,439,000	$ 710,000	$ 608,668	
Administration and Management	$ 720,000	$ 355,000	$ 237,682	
Unknown				$2,069,934[3]
Totals	**$16,547,000**	**$8,161,000**	**$7,369,934**	**$7,069,934**
Per capita	$25.82	$12.73	approx. $5	

Proposed Amendments: Using the CDC *Best Practices* as guidance as to minimum recommendations for an effective tobacco prevention program, the Medical Association proposes the following amendments to Reengrossed SB 2380:

- The proposed amendments would allocate in the future one-third of the tobacco settlement funds to a state tobacco prevention fund for the purpose of implementing the tobacco use prevention and dependence treatment plan, subject to future appropriation by the Legislative Assembly.

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[1] Governor Hoeven's Plan provides $5,753,799 for the 2001-03 biennium for community programs that include chronic disease programs, school programs and cessation programs.

[2] Reengrossed SB 2380 in section 9 lists items for funding from the appropriation from the community health trust fund, including an amount not to exceed $4 million for a healthy schools grant program that provides grants to schools for tobacco cessation programs, and a healthy communities grant program. .0

[3] Engrossed SB 2004 appropriates $7,069,934 for "tobacco prevention and control," which includes $2,369,934 in federal funds from CDC and $4,700,000 from the community health trust fund. The Statement of Purpose of Amendment for SB 2004 states that the funds are to be used for implementation of programs in SB 2380, which includes the list of appropriated items in section 9 of Reengrossed SB 2380, including $1,000,000 for aid to public health units.

- The proposed amendments would remove the appropriation "list" in section 9, leaving the appropriation for SB 2380 in SB 2004. The removal of this language assures that the appropriation in SB 2004 is used to implement the state plan envisioned by SB 2380.

- The proposed amendments would remove the reference to the state health officer as being a member of the advisory committee. The purpose of the advisory committee is to advise the state health officer; therefore, the state health officer should not be a member of the committee Instead, the state tobacco prevention control coordinator would serve on the committee. In addition, the proposed amendments would ensure that the committee uses technical experts that are trained in the CDC *Best Practices.*

- The proposed amendments would give interested persons an opportunity to provide input to the committee in developing the proposed state plan before the committee proposes a plan.

- The proposed amendments would ensure that the CDC *Best Practices* form the basis for the state plan.

- The proposed amendments would clarify that the cost for the annual statewide assessment of tobacco-related behaviors and attitudes among youth be funded from the ongoing monitoring and evaluation component of the plan, and not from the administrative component of the plan.

The North Dakota Medical Association stands ready to provide information and technical assistance from physicians if necessary to assist the committee. We urge the Committee to consider the proposed amendments to Reengrossed SB 2380.

PROPOSED AMENDMENTS TO REENGROSSED SB 2380

Page 1, line 2, remove "subsection 1 of"

Page 2, line 13, remove "state health officer or the state health officer's designee, who may be the"
Page 2, line 27, remove "members of"
Page 2, line 30, replace "may" with "shall"

Page 3, line 1, replace "as it may require" with "who are trained in the centers for disease control and prevention's best practices for comprehensive tobacco control programs"
Page 3, line 21, after "treatment" insert ", after providing a reasonable opportunity for interested persons to submit data or views to the committee regarding a plan"

Page 4, line 3, after "integrates" with "only"
Page 4, line 10, after "include" insert "only"
Page 4, line 17, after the underscored semicolon insert "or"
Page 4, line 19, replace "; or" with an underscored period
Page 4, remove line 20
Page 4, line 21, after "provide" insert ", as part of the ongoing monitoring and evaluation component of the plan,"

Page 5, line 25, after "qualified" insert "tobacco prevention"

Page 6, replace lines 16 through 30 with :

"**SECTION 10. AMENDMENT.** Section 54-27-25 of the 1999 Supplement to the North Dakota Century Code is amended and reenacted as follows:

54-27-25. Tobacco settlement trust fund - Interest on fund - Uses. There is created in the state treasury a tobacco settlement trust fund. The fund consists of the tobacco settlement dollars obtained by the state under sections IX (payments) and XI (calculation and disbursement of payments) of the master settlement agreement and consent agreement adopted by the east central judicial district court in its judgment entered December 28, 1998 [Civil No. 98-3778]. All moneys received by the state pursuant to the judgment and all moneys received by the state for enforcement of the judgment must be deposited in the fund. Interest earned on the fund must be credited to the fund and deposited in the fund. After the effective date of this Act, one-third of the principal and all interest on the funds deposited in the tobacco settlement trust fund must be deposited in the state tobacco prevention fund to be administered by the state department of health. The state department of health may use funds in the tobacco prevention fund as appropriated for implementing the tobacco use prevention and dependence treatment plan pursuant to sections 1 through 8 of this Act. The remaining principal and interest of the tobacco settlement trust fund must be allocated as follows:

1. Transfers to a community health trust fund to be administered by the state department of health. The state department of health may use funds as appropriated for community-based public health programs and other public health programs~~, including programs with emphasis on preventing or reducing tobacco usage in this state~~. Transfers under

this subsection must equal ten percent of total annual transfers from the tobacco settlement trust fund, less amounts transferred to the tobacco prevention fund.

2. Transfers to the common schools trust fund to become a part of the principal of that fund. Transfers under this subsection must equal forty-five percent of total annual transfers from the tobacco settlement trust fund, less amounts transferred to the tobacco prevention fund.
3. Transfers to the water development trust fund to be used to address the long-term water development and management needs of the state. Transfers under this subsection must equal forty-five percent of the total annual transfers from the tobacco settlement trust fund, less amounts transferred to the tobacco prevention fund.

Notwithstanding the provisions of this section, during each biennium transfers that would be made to the common schools trust fund under subsection 2 must instead be transferred to the water development trust fund until the state water commission certifies to the state treasurer that deposits in the water development trust fund during that biennium are sufficient to pay the principal and interest for that biennium on bonds authorized under section 61-02.1-01. When that certification is received, the state treasurer shall determine the amount deposited in the water development trust fund during that biennium and transfers that would be made to the water development trust fund under subsection 3 must instead be transferred to the common schools trust fund until deposits in the common schools trust fund during that biennium are equal to the amount deposited in the water development trust fund during that biennium or until the end of the biennium, whichever occurs first.

Transfers to the funds under this section must be made within thirty days of receipt by the tobacco settlement trust fund."

Page 7, remove lines 1 through 15

Renumber accordingly

3 29-01

Testimony on Second Reengrossed SB 2380 / Engrossed SB 2004
House Appropriations Committee
March 29, 2001

The North Dakota Medical Association supports the forward steps being considered by the Legislative Assembly to fund a comprehensive tobacco prevention and treatment dependence program in our state that is based on the Centers for Disease Control and Prevention's *Best Practices for Comprehensive Tobacco Control Programs*. Just two days ago, the Surgeon General released a comprehensive report: *Women and Smoking: A Report of the Surgeon General – 2001*, that reaffirms the need for states to enact comprehensive programs using the CDC *Best Practices* "because they work." The Association urges the Committee to carefully consider the funding mechanism of allocations to public health units and other language in the reengrossed bill and adopt amendments to assure that funds are appropriated exclusively for a comprehensive program based on the Centers for Disease Control and Prevention's *Best Practices for Comprehensive Tobacco Control Programs*.

North Dakota physicians support the development of an adequately funded, comprehensive tobacco prevention and dependence treatment program.

Tobacco use is the single most preventable cause of death in the United States and in North Dakota. Not only would a comprehensive program diminish the individual family tragedies associated with tobacco-related disease and death, but would also help stem the rising cost of health care for families and businesses in North Dakota.

Last fall, North Dakota's physicians through NDMA's House of Delegates adopted a resolution supporting the development in North Dakota of a science-based, comprehensive tobacco prevention and dependence treatment program, using one-third of the tobacco settlement funds for this purpose.

In coming to that conclusion, physicians relied on the following points:

The use of tobacco products by North Dakota citizens has resulted in devastating health and economic consequences, including 1050 deaths each year, and healthcare expenditures of over $180 million (over 11% of all health care expenditures in North Dakota) -- the burden being imposed on taxpayers, businesses, individuals, and government.

Tobacco companies spend $12 million annually advertising their products in North Dakota, influencing more than 22% of our citizens to smoke and chew tobacco and giving our state the third highest youth smoking rate in the nation.

Primary care physicians in North Dakota are in the unique position of seeing the tragic effects of smoking and second-hand smoke in their patients on a daily basis, including cases of heart disease, lung cancer, emphysema, bronchitis, pneumonia, sinusitis, and ear infections in both adults and children.

The North Dakota Chapters of the American Academy of Family Physicians, the American Academy of Pediatrics, and the American College of Physicians – American Society of Internal Medicine have each given their support to a strong tobacco education and prevention program in North Dakota.

The U.S. Centers for Disease Control has developed a science-based approach to tobacco prevention and cessation illustrating "best practices" strategies and programs to be implemented on a state-wide basis, including community programs to reduce tobacco use, chronic disease programs, school programs, enforcement efforts, statewide programs, countermarketing, and cessation programs. Research shows

that these best practice strategies are most effective when they are all integrated into a comprehensive program. The experience in other states with comprehensive programs such as Massachusetts, California, Oregon and Florida shows that, when adequately funded, these comprehensive programs can quickly and substantially reduce tobacco use.

Scientific knowledge and strategies exist to reduce tobacco use, and can serve as the foundation for action in North Dakota

The Surgeon General of the United States, as well as the Centers for Disease Control and Prevention and the Institute of Medicine, have documented evidence showing that multi-faceted, state-based tobacco control programs are effective in reducing tobacco use. The Surgeon General's 2000 report: *Reducing Tobacco Use* provides an in-depth review of the effectiveness of tobacco intervention strategies. The evidence reviewed in the report shows that comprehensive state tobacco control programs are effective in reducing tobacco use because they bring about a shift in social norms and reduce the broad cultural acceptability of tobacco use. According to the Surgeon General's report, the components of a multi-faceted approach include: (1) community interventions, which include diverse entities such as schools, health agencies, city and county governments, and civic, social, and recreation organizations, (2) countermarketing, which includes using media advocacy, paid media, prohealth promotions, and other media strategies to change social norms regarding tobacco use, (3) program policy and regulation, which addresses such issues as minors' access, tobacco pricing, advertising and promotion, clean indoor air, product regulation, and tobacco use cessation, and (4) surveillance and evaluation, which includes monitoring tobacco industry promotional campaigns, evaluating the economic impact of environmental tobacco smoke (ETS) laws and policies, conducting surveys of public opinion on program interventions, and other activities to make ongoing refinements that lead to more effective prevention strategies.

The Surgeon General's report notes that the synergy created by the interaction of various program components in a comprehensive approach is believed to be responsible for increased success in reducing tobacco use. The report states, in addressing the need for comprehensive approaches:

> The evidence of effectiveness summarized in this report emphasizes that public health success in reducing tobacco use requires activity using multiple modalities. A comprehensive approach – one that optimizes synergy from applying a mix of educational, clinical, regulatory, economic, and social strategies – has emerged as the guiding principle for future efforts to reduce tobacco use. The public health goals of such comprehensive programs are to reduce disease, disability, and death related to tobacco use through prevention and cessation, as well as through protection of the nonsmoker from ETS.

Attached to this testimony are copies of relevant portions of the 2000 Surgeon General's Report. *Reducing Tobacco Use*, which also includes descriptions of major programs developed in Minnesota, California, Massachusetts, Arizona, Oregon, Maine, Mississippi, Florida, and Texas. Also attached is a recent CDC publication, *Investment in Tobacco Control: State Highlights 2001*, which describes activities of states to reduce tobacco use and provides an executive summary of the *CDC Best Practices for Comprehensive Tobacco Control Programs*. Also included is a report generated from a panel convened by the former Attorney General, in an effort that involved a number of physicians in identifying a comprehensive, science-based approach to tobacco prevention and dependency treatment in North Dakota. We urge the Committee to review all these important documents, which describe the components and merits of a comprehensive approach to reducing tobacco use in North Dakota.

The evidence shows that multi-faceted, state-based tobacco control programs are effective in reducing tobacco use. However, the evidence shows that those programs must also be adequately funded to be effective.

The Centers for Disease Control and Prevention recommends in *Best Practices for Comprehensive Tobacco Control Programs*, August 1999, that North Dakota fund annual allocations for each program component as follows, with comparison to the biennial allocations proposed in Governor Hoeven's plan and the first Reengrossed SB 2380 and Engrossed SB 2004 as passed in the Senate:

	CDC Upper Estimate (Annual Est.)	CDC Lower Estimate (Annual Est.)	Governor's Plan (Biennium)	SB 2380 2004 Senate Version (Biennium)
Community Programs to Reduce Tobacco Use	$2,482,000	$1,299,000		
Chronic Disease Programs to Reduce The Burden of Tobacco-Related Diseases	$4,162,000	$2,787,000		
School Programs	$1,498,000	$ 999,000		
Cessation Programs	$2,865,000	$ 687,000		
Subtotal	**$11,007,000**	**$5,772,000**	**$5,753,799**[1]	**$4,000,000**[2]
Enforcement	$ 817,000	$ 426,000		
Statewide Programs	$ 641,000	$ 257,000	$ 220,332	
Counter-Marketing	$1,923,000	$ 641,000	$ 549,453	$1,000,000
Surveillance and Evaluation	$1,439,000	$ 710,000	$ 608,668	
Administration and Management	$ 720,000	$ 355,000	$ 237,682	
Unknown				$2,069,934[3]
Totals	**$16,547,000**	**$8,161,000**	**$7,369,934**	**$7,069,934**
Per capita	$25.82	$12.73	approx. $5	

The second engrossed version of SB 2380 before this committee makes specific allocations of appropriations to public health units without requiring that those funds be used exclusively for

---

[1] Governor Hoeven's Plan provides $5,753,799 for the 2001-03 biennium for community programs that include chronic disease programs, school programs and cessation programs.

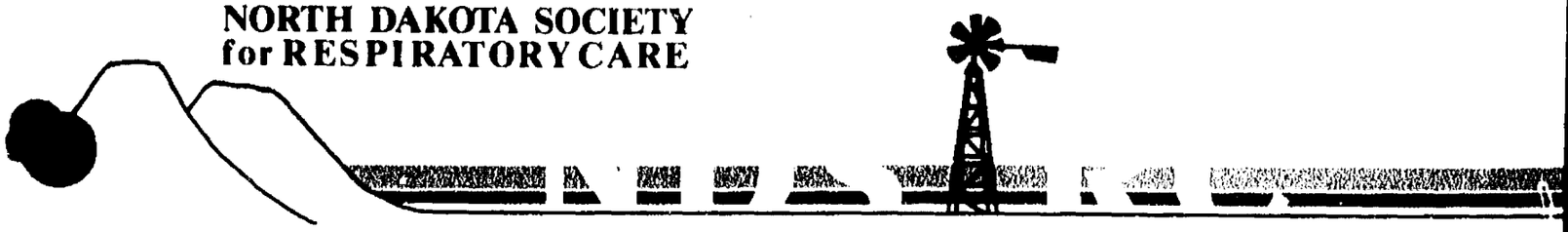
[2] Reengrossed SB 2380 in section 9 lists items for funding from the appropriation from the community health trust fund, including an amount not to exceed $4 million for a healthy schools grant program that provides grants to schools for tobacco cessation programs, and a healthy communities grant program that is not described, other than to include eligibility criteria that includes a 100% matching funds requirement and a requirement that eligibility be based on a community's effectiveness in enforcing state and local tobacco seller and use laws and ordinances and reducing incidence of youth smoking and other high-risk behaviors.

[3] Engrossed SB 2004 appropriates $7,069,934 for "tobacco prevention and control," which includes $2,369,934 in federal funds from CDC and $4,700,000 from the community health trust fund. The Statement of Purpose of Amendment for SB 2004 states that the funds are to be used for implementation of programs in SB 2380, which includes the list of appropriated items in section 9 of Reengrossed SB 2380, including $1,000,000 for aid to public health units

tobacco prevention and dependence treatment, and without assurances that the Department of Health will be able to establish a comprehensive program under those funding restrictions.

The North Dakota Medical Association stands ready to provide information and technical assistance from physicians if necessary to assist the Committee. We urge the Committee to consider the proposed amendments to Reengrossed SB 2380.

NORTH DAKOTA SOCIETY for RESPIRATORY CARE



"A BREATH OF FRESH CARE"

March 6, 2001

Testimony of: Glenn Thom, BS, MMgt, RRT
President, North Dakota Society for Respiratory Care (NDSRC)

RE: SB 2380, Reengrossed

Respiratory therapists treat North Dakota citizens who have lung disease. These patients include not only young asthmatics who suffer from second-hand tobacco smoke, but also emphysema patients who are facing terminal lung disease from long-term tobacco use.

The NDSRC supports SB 2380. This bill is a good start for tobacco control in this state. SB 2380 is a move toward satisfying the expectations of North Dakota citizens as identified in the statewide poll by Winkleman Consulting of Fargo. As you may know, this poll indicated that close to 70% of our citizens expect tobacco settlement funds to be used for tobacco control.

Another study accomplished just last year specifically tailored the Centers for Disease Control's (CDC) *Best Practices for Comprehensive Tobacco Control Programs* to the needs identified in North Dakota. The results show that the minimum amount needed for a comprehensive program is $16 million per biennium.

Every state that has experienced notable success with tobacco control has demonstrated that only comprehensive tobacco control programs work. We continue to see a persistently high use of tobacco products in North Dakota. Based on scientific evidence for effective tobacco control, our continued high tobacco use can be seen as a direct result of inadequate control-efforts.

North Dakota is a state that has a history of looking out for the best for its citizens. We have worked in the past to do the best we can with the information and resources we have available at any time.

We now have the unique opportunity of both the best information and more than sufficient resources available to continue doing the best for our people. I ask that this committee allocate sufficient funding to cover CDC-recommended minimum funding levels and that it be apportioned to fund categories of activity identified in the CDC's *Best Practices* guidelines.

Thank you for your timely consideration.

North Dakota Office of
Attorney General

Statewide Poll on the Use of Tobacco Settlement Funds

Prepared by

WINKELMAN CONSULTING

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January 2001

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The purpose of this research study was to:

- Identify residents' support for (or opposition to) various uses of funds the State will receive as a result of the settlement with the tobacco industry.
- For selected questions, determine whether opinions have changed since 1998.

Sampling Frame & Sample Size

The population for this study consisted of adults living in the state of North Dakota. Telephone numbers were obtained from a list company that specializes in generating samples for survey research. A proportionate-stratified, random-systematic sampling technique was employed in this study to select respondents. The state was stratified using the boundaries for the eight planning regions.

Margin of Error

The 801 completed questionnaires provide a 95% confidence level with an overall minimum and maximum margin of error of ±2.1% and ±3.5%, respectively, in estimating the proportion of the population who possess a certain characteristic or opinion. In other words, if 100 samples (all of 801 in size) were drawn from this population, approximately 95 of the samples would have proportions within ±2.1% and ±3.5% of the proportions of the entire population for the characteristic or opinion being measured.

The margin of error explained previously only applies to responses of the *entire* sample. As is shown in the next chart, the margin of error will be larger when looking at the responses of smaller segments.

Populations	Surveys	Households	Margin of Error for results at or about...				
			10%/90%	20%/80%	30%/70%	40%/60%	50%/50%
Total Sample	801	241,802	2.1%	2.8%	3.2%	3.4%	3.5%
Region 1 - Williston	38	11,541	9.5%	12.7%	14.5%	15.6%	15.9%
Region 2 - Minot	113	34,277	5.5%	7.4%	8.4%	9.0%	9.2%
Region 3 - Devils Lake	55	16,614	7.9%	10.6%	12.1%	12.9%	13.2%
Region 4 - Grand Forks	119	36,110	5.4%	7.2%	8.2%	8.8%	9.0%
Region 5 - Fargo	184	55,427	4.3%	5.8%	6.6%	7.1%	7.2%
Region 6 - Jamestown	86	26,095	6.3%	8.4%	9.7%	10.3%	10.6%
Region7 - Bismarck	155	46,263	4.7%	6.3%	7.2%	7.7%	7.9%
Region 8 - Dickinson	51	15,475	8.2%	11.0%	12.6%	13.4%	13.7%
General	700	211,313	2.2%	3.0%	3.4%	3.6%	3.7%
Sub-segments	650	196,219	2.3%	3.1%	3.5%	3.8%	3.8%
	600	181,125	2.4%	3.2%	3.7%	3.9%	4.0%
	550	166,031	2.5%	3.3%	3.8%	4.1%	4.2%
	500	150,938	2.6%	3.5%	4.0%	4.3%	4.4%
	450	135,844	2.8%	3.7%	4.2%	4.5%	4.6%
	400	120,750	2.9%	3.9%	4.5%	4.8%	4.9%
	350	105,656	3.1%	4.2%	4.8%	5.1%	5.2%
	300	90,563	3.4%	4.5%	5.2%	5.5%	5.6%
	250	75,469	3.7%	5.0%	5.7%	6.1%	6.2%
	200	60,375	4.2%	5.5%	6.3%	6.8%	6.9%
	150	45,281	4.8%	6.4%	7.3%	7.8%	8.0%
	100	30,188	5.9%	7.8%	9.0%	9.6%	9.8%
	75	22,641	6.8%	9.0%	10.4%	11.1%	11.3%
	50	15,094	8.3%	11.1%	12.7%	13.6%	13.8%
	25	7,547	11.7%	15.7%	17.9%	19.2%	19.6%

** The maximum margin of error is shown in the "50%/50%" column and the minimum margin of error is shown in the "10%/90%" column.*

Collection Technique & Timing

All data was collected through the use of telephone interviews. Data collection was conducted from January 4 - 8, 2001. The data collection was completed in compliance with specifications established by Winkelman Consulting. Interviewing was supervised and performed by trained personnel from the Heritage Marketing Group.

When reviewing the executive summary, the findings and conclusions will be more thoroughly understood if several other sections of the report are also reviewed. First, the questionnaire in Section 4 provides the actual phrasing for each question. A solid understanding of the context in which each question was asked will enable you to more accurately interpret the findings. Second, the contingency tables in Section 5 provide detailed results for many different sample segments. Since the condensed nature of this summary report format does not allow us to address all of these findings, we strongly recommend that you review the contingency tables and use them to facilitate any major decisions you make.

Purpose #1: Identify residents' support for (or opposition to) various uses of funds the State will receive as a result of the recent settlement with the tobacco industry.

γ Conclusion #1: Nearly eight of every ten North Dakotans "strongly favor" using the tobacco settlement funds for efforts that will reduce tobacco use among children. Of the other uses measured in the survey, only education had more than five of every ten respondents "strongly favor" using the funds for that purpose *(see Figure 1a)*

When the "strongly favor" and "somewhat favor" responses are combined, we see that more than nine of every ten respondents favor using the tobacco settlement funds for efforts that will reduce tobacco use among children *(see Figure 1b)*

Slightly higher proportions of women, those from central regions in the state (Regions 2, 3, 6, & 7), and "Metro" areas and "towns" said they "strongly favor" using the tobacco settlement funds for efforts that will reduce tobacco use among children.

- Conclusion #2: Nearly seven of every ten respondents feel at least half of the settlement funds should be spent on efforts to reduce tobacco use among children *(see Figure 2)*.

  - Slightly higher proportions of women and those living in "Metro" areas said that at least half of the settlement funds should be spent on efforts to reduce tobacco use among children.

Purpose #2: For selected questions, determine whether opinions have changed since 1998.

The maximum margin of error for this study is ±3.5%, while the maximum margin of error for the 1998 study was ±4.0%. Therefore, most changes greater than 4% can be considered to be "significant" changes.

- Conclusion #1: For the three uses measured in both 1998 and 2001, all three saw significant increases in the proportion of respondents who "strongly favor" using tobacco settlement funds for that purpose *(see Figure 1a)*. However, please note that much of the increase in using these funds for education results from a change in the question wording.

  - 1998: What is your reaction to the state spending the tobacco settlement money on building more schools and hiring more teachers?

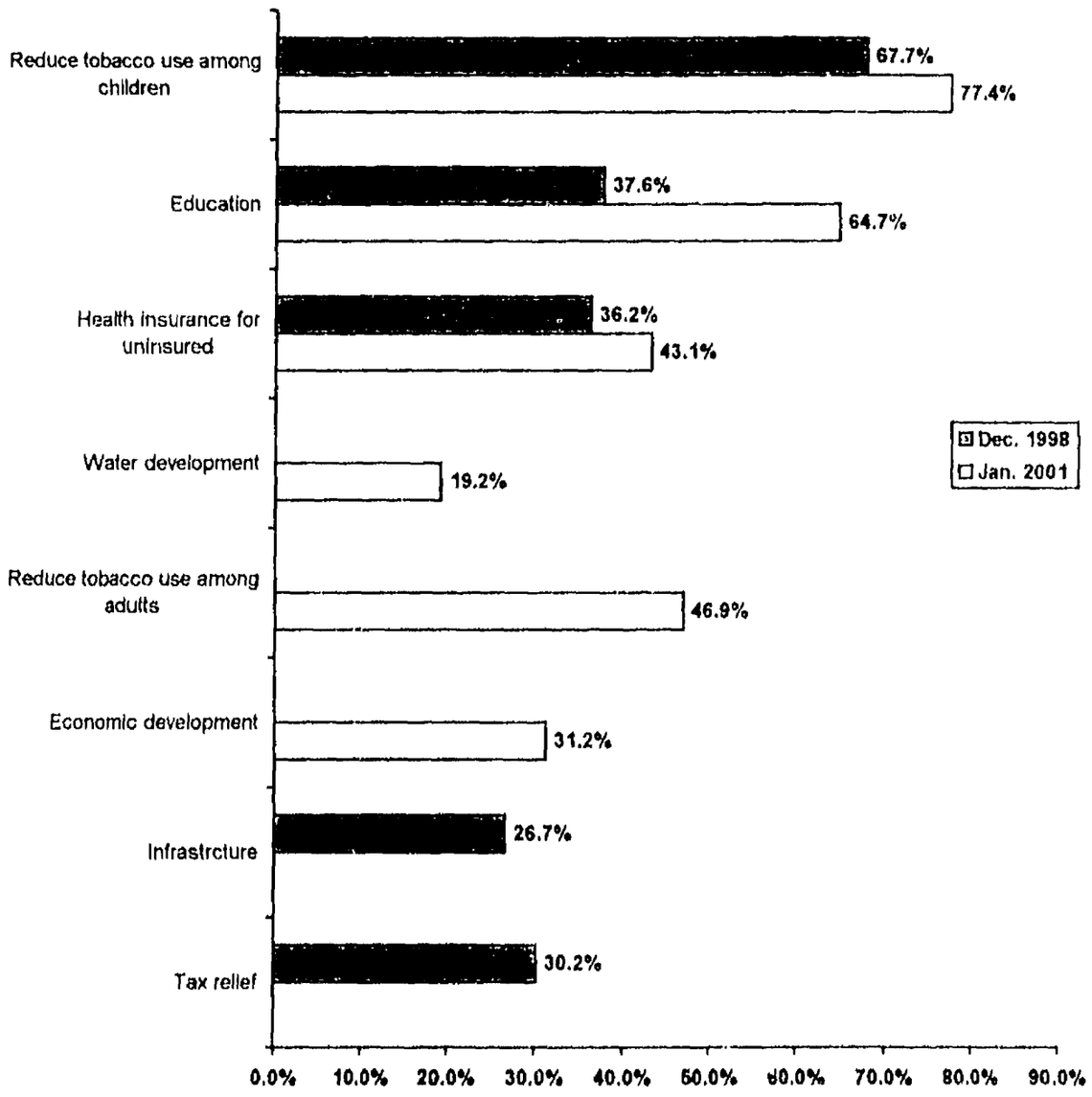
  - 2001: What is your reaction to the state spending the tobacco settlement money on education funding?

- Conclusion #2: The proportion of respondents who feel at least half of the tobacco settlement funds should be spent on efforts to reduce smoking among kids also increased, moving from 62.3% in 1998 to 67.6% in 2001 *(see Figure 2)*.

Section 3

FIGURES & CHARTS

Figure 1a. Proportion of respondents that strongly favor using tobacco settlement funds for the following purposes:
(Includes all respondents)



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Figure 1b. Proportion of respondents that at least somewhat favor using tobacco settlement funds for the following purposes:
(Includes all respondents)

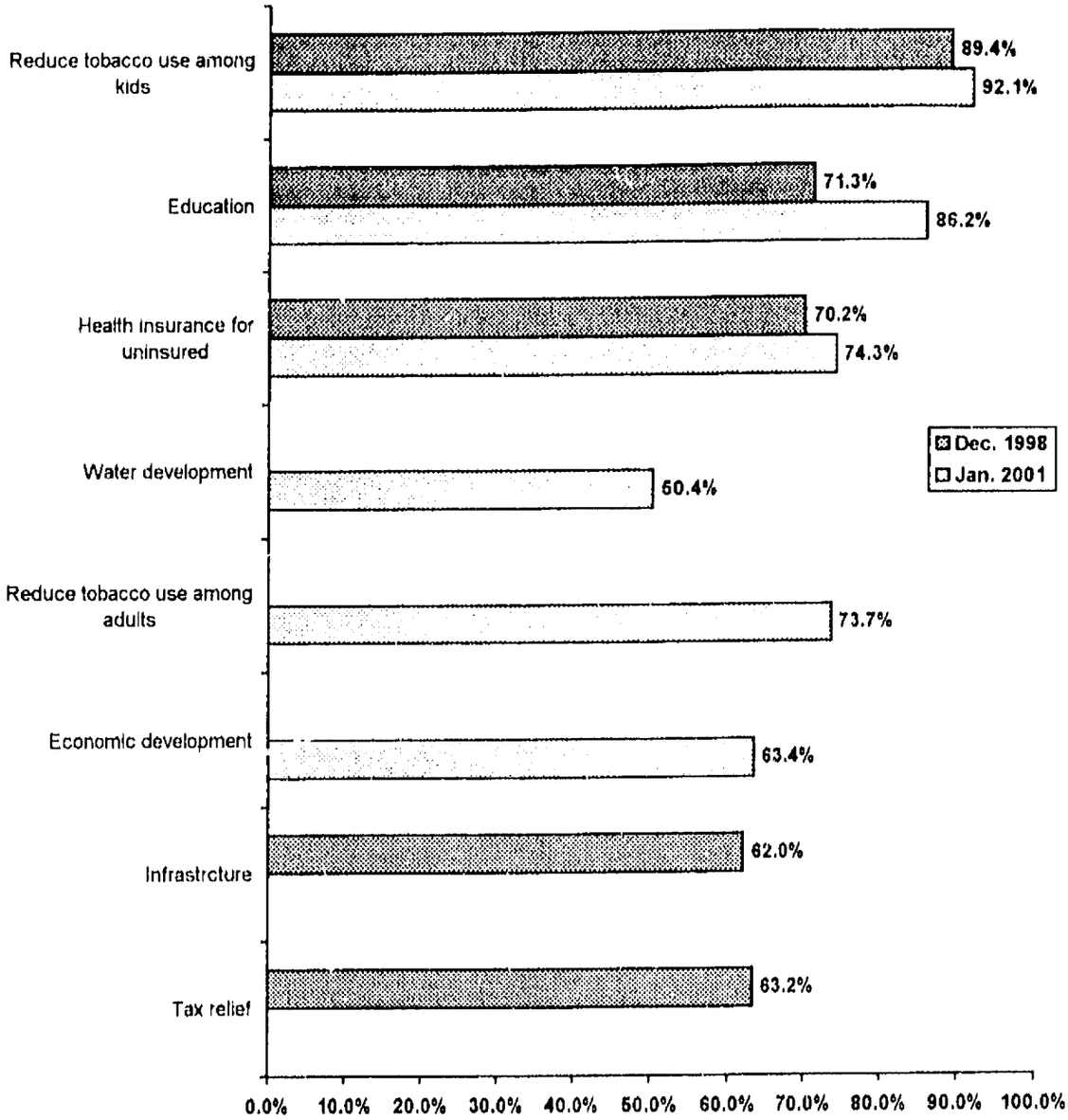
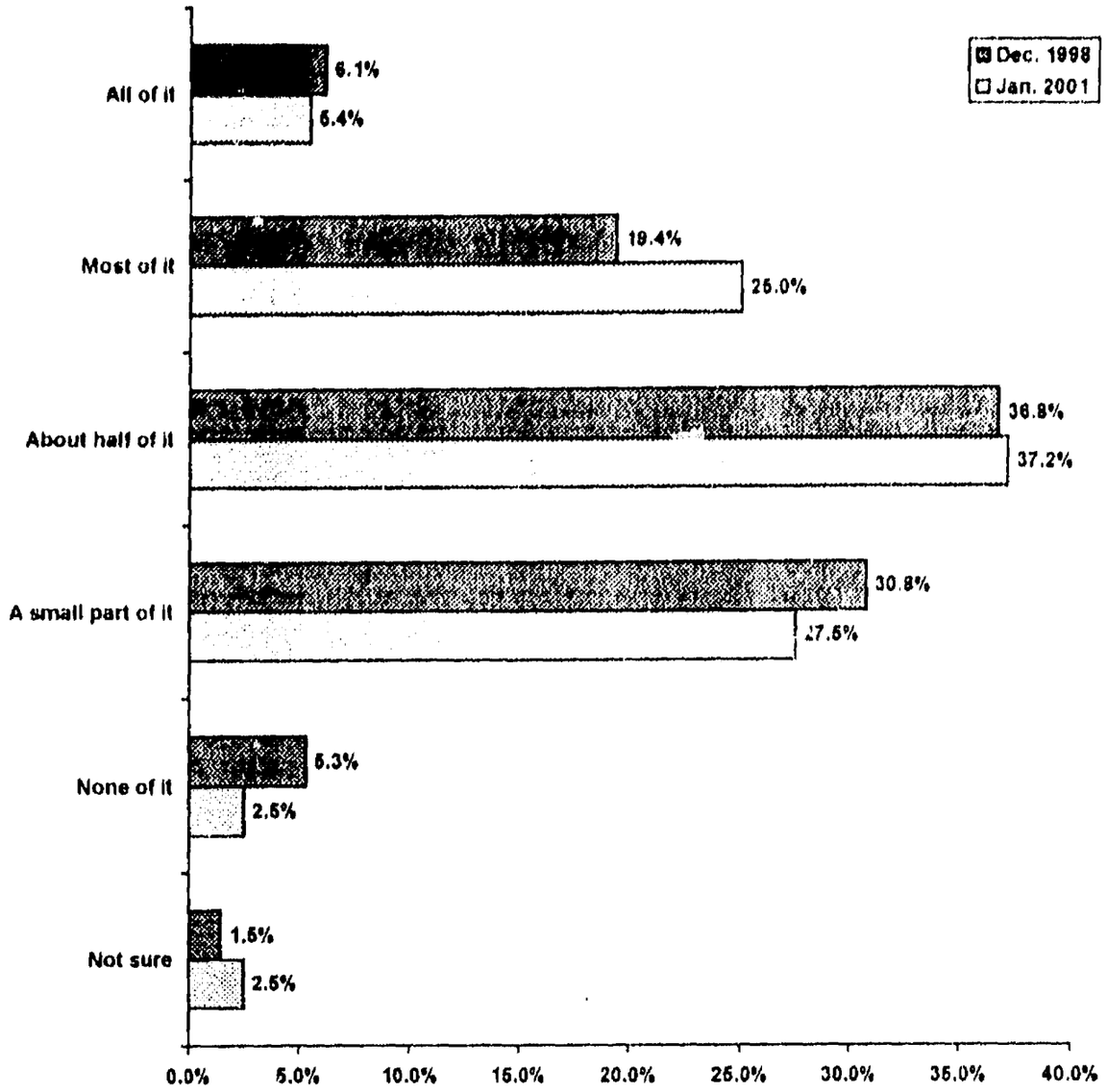


Figure 2. **How much of the settlement funds do you feel should be spent on efforts to reduce smoking among children?** *(Includes all respondents)*



The following questionnaire was designed with assistance from Rosey Sand from the Office of Attorney General.

The questionnaire in this report was used for all interviews conducted for this study.

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Data Entry # _____ Interviewer Name: _____ Employee #: _____

Date: ____/____/____ Start Time: ____:____ a.m. p.m. Respondent #: _____

[redacted]y name is *(Your First Name)* from Winkelman Research in Fargo, and I'm <u>not</u> selling anything -- I'm simply conducting a survey about the settlement between the tobacco industry and the state of North Dakota. The survey will only take about 2 or 3 minutes, there are <u>no right or wrong answers</u>, and your answers will be kept confidential. This survey is for people 18 or older. Are you 18 years of age or older?

Y..... Yes

[IF ... speak to someone 18+. ← ← ← N..... No/Not Sure/No Response
Call back (CB) if NOT available.

Q1-6. **As you may know, in 1998 the state of North Dakota sued the tobacco industry for money the state has spent treating smoking-related illnesses. The tobacco industry reached a settlement with North Dakota, so the state will receive millions of dollars each year for the next 25 years. I'm going to read a short list of ways money from the settlement <u>could</u> be spent. After I read each, please tell me if you strongly favor, somewhat favor, somewhat oppose, or strongly oppose spending the settlement money in that way.**

ROTATE Place an "X" next to the item read first

What is your reaction to the state spending the tobacco settlement money on...	Strongly favor	Somewhat favor	Somewhat oppose	Strongly oppose	Not sure
Q1. **Efforts to reduce tobacco use among kids?**	1	2	3	4	91
Q2. **Water development efforts?**	1	2	3	4	91
Q3. **Efforts to reduce tobacco use among adults?**	1	2	3	4	91
Q4. **Economic development efforts?**	1	2	3	4	91
Q5. **Education funding?**	1	2	3	4	91
Q6. **Providing health insurance for uninsured people in the state?**	1	2	3	4	91

Q7. **In your opinion, how much of the money that the state receives from the tobacco settlement should be spent on efforts to reduce smoking among kids – would you say ...**

1 ..... **All of it,**
2 ..... **Most of it,**
3 ..... **About half of it,**
4 ..... **A small part of it, or**
5 ..... **None of it?**
91 ..... *[Do Not Read]* Not sure/No response

Q8 *[AGE]* **For classification purposes, may I have your age please?** *[IF RELUCTANT OR REFUSE, READ GROUPS:* **Please stop me when I read the age group which includes you...]**

1 ..... **18 to 24,**
2 ..... **25 to 40,**
3 ..... **41 to 64, or**
4 ..... **65 or older?**
91 ..... *[Do Not Read]* Choose not to answer

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VERIFICATION CLOSE: **That's all the questions I have for you. Lastly, let me verify that I dialed ____-_____. Again, my name is** (Your First Name), **and on occasion a small percentage of people like yourself are [illegible]d back just to verify that this interview actually took place. May I please have your first name, and first [illegible]e only, so my supervisor will know who to ask for in case this interview is verified. Thank you for your time and have a good evening/day.**

Resp First Name_____ Phone (_____) _____-_____ End Time_____

Q9 *[SEX] [Do Not Read]* Enter respondent's gender
1.....Male
2.....Female

Q10 *[ZIP] [Do No Read]* Enter zip code from list _____

Q11 *[AREA] [Do Not Read]* Enter region code from list _____

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Contingency tables are commonly referred to as "cross-tabs". They present the findings in an easy-to-understand, table form and provide the categorical data that is used most frequently in marketing. We strongly recommend that you review these tables and use them to facilitate any major decisions you make.

The contingency tables on the following pages show the proportion of all respondents who gave various responses to each question, as well as the proportion of specific sample segments (i.e. gender, age group, area of residence, etc.) who provided a particular response. This detail will enable you to determine which segments are more likely (or less likely) to have certain opinions.

Please note the tables are separated into sections. The tables in each section have the same "banners" or sample segments across the top. Within each section, the tables are in order by question number, which appears on the top, left-hand side of each table.

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Q1 - Q3: By Age & Gender

		Total	Q8. Age.					Q9. Gender	
			18 to 24	25 to 40	41 to 64	65 +	Refuse	Male	Female
Q1. Reaction to using tobacco funds on efforts to reduce tobacco use among kids?	Strongly favor	77.4%	65.3%	78.0%	79.2%	76.2%	100.0%	69.4%	83.3%
	Somewhat favor	14.7%	20.4%	16.9%	14.2%	12.6%		20.3%	10.6%
	Somewhat oppose	3.2%	8.2%	2.8%	2.7%	3.4%		5.6%	1.5%
	Strongly oppose	2.0%	4.1%	1.1%	1.6%	2.9%		1.5%	2.4%
	Not sure	2.6%	2.0%	1.1%	2.2%	4.9%		3.2%	2.2%
Q2. Reaction to using tobacco funds on water development efforts?	Strongly favor	19.2%	30.6%	14.1%	17.0%	25.2%		20.6%	18.2%
	Somewhat favor	31.2%	28.6%	37.9%	28.8%	30.6%	25.0%	29.4%	32.5%
	Somewhat oppose	22.0%	16.3%	23.7%	27.1%	12.6%	25.0%	24.4%	20.2%
	Strongly oppose	14.5%	10.2%	11.9%	17.5%	12.1%	25.0%	17.1%	12.6%
	Not sure	13.1%	14.3%	12.4%	9.6%	19.4%	25.0%	8.5%	16.5%
Q3 Reaction to using tobacco funds on efforts to reduce tobacco use among adults?	Strongly favor	46.9%	55.1%	46.9%	49.3%	41.3%	25.0%	44.4%	48.8%
	Somewhat favor	26.8%	12.2%	34.5%	27.1%	23.3%	25.0%	25.6%	27.8%
	Somewhat oppose	11.5%	14.3%	10.2%	11.0%	12.6%	25.0%	11.8%	11.3%
	Strongly oppose	10.0%	12.2%	7.3%	8.8%	13.6%	25.0%	13.5%	7.4%
	Not sure	4.7%	6.1%	1.1%	3.8%	9.2%		4.7%	4.8%
Total Responses		801	49	177	365	206	4	340	461

Includes all respondents

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Q4 - Q6: By Age & Gender

		Total	Q8. Age.					Q9 Gender.	
			18 to 24	25 to 40	41 to 64	65 +	Refuse	Male	Female
Q4. Reaction to using tobacco funds on economic development efforts?	Strongly favor	31.2%	51.0%	31.6%	27.9%	32.0%	25.0%	32.1%	30.6%
	Somewhat favor	32.2%	20.4%	35.0%	31.8%	33.5%	25.0%	27.9%	35.4%
	Somewhat oppose	13.1%	6.1%	13.6%	16.4%	8.3%	25.0%	16.8%	10.5%
	Strongly oppose	14.6%	8.2%	16.4%	16.2%	12.1%		16.5%	13.2%
	Not sure	8.9%	14.3%	3.4%	7.7%	14.1%	25.0%	6.8%	10.4%
Q5. Reaction to using tobacco funds on education funding?	Strongly favor	64.7%	81.6%	65.0%	60.5%	68.0%	50.0%	56.8%	70.5%
	Somewhat favor	21.5%	16.3%	21.5%	24.9%	16.5%	25.0%	25.3%	18.7%
	Somewhat oppose	5.7%		4.0%	8.8%	3.4%		6.2%	5.4%
	Strongly oppose	6.5%	2.0%	8.5%	5.2%	8.3%		10.3%	3.7%
	Not sure	1.6%		1.1%	.5%	3.9%	25.0%	1.5%	1.7%
Q6. Reaction to using tobacco funds to provide health insurance for uninsured?	Strongly favor	43.1%	55.1%	37.3%	40.3%	50.5%	25.0%	39.4%	45.8%
	Somewhat favor	31.2%	26.5%	36.2%	31.5%	27.2%	50.0%	28.2%	33.4%
	Somewhat oppose	12.7%	8.2%	17.5%	15.9%	4.4%		17.4%	9.3%
	Strongly oppose	9.0%	10.2%	6.2%	9.0%	11.2%		12.1%	6.7%
	Not sure	4.0%		2.8%	3.3%	6.8%	25.0%	2.9%	4.8%
Total Responses		801	49	177	365	206	4	340	461

Includes all respondents

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Q7: By Age & Gender

		Total	Q8. Age					Q9. Gender	
			18 to 24	25 to 40	41 to 64	65 +	Refuse	Male	Female
Q7. How much of tobacco funds should be spent to reduce smoking among kids?	All of it	5.4%	10.2%	3.4%	4.1%	8.3%		5.9%	5.0%
	Most of it	25.0%	34.7%	31.6%	21.9%	21.8%	50.0%	22.9%	26.5%
	About half	37.2%	28.6%	39.5%	41.9%	29.1%	25.0%	35.9%	38.2%
	Small part of it	27.5%	24.5%	23.7%	27.7%	31.1%	25.0%	30.0%	25.6%
	None of it	2.5%	2.0%	1.1%	2.7%	3.4%		3.2%	2.0%
	Not sure	2.5%		.6%	1.6%	6.3%		2.1%	2.8%
Total Responses		801	49	177	365	206	4	340	461

Includes all respondents

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Demographics: By Age & Gender

		Total	Q8 Age					Q9 Gender	
			18 to 24	25 to 40	41 to 64	65 +	Refuse	Male	Female
Q11. Planning region	Region 1 - Williston	4.7%		5.1%	3.8%	7.3%		3.5%	5.6%
	Region 2 - Minot	14.1%	20.4%	14.1%	12.6%	15.5%		15.6%	13.0%
	Region 3 - Devils Lake	6.5%	4.1%	4.5%	6.0%	10.7%	25.0%	4.4%	8.7%
	Region 4 - Grand Forks	14.9%	12.2%	14.7%	15.6%	14.1%	25.0%	14.1%	15.4%
	Region 5 - Fargo	23.0%	26.5%	27.1%	24.1%	16.5%	25.0%	25.9%	20.8%
	Region 6 - Jamestown	10.7%	12.2%	6.8%	11.0%	13.6%		12.1%	9.5%
	Region 7 - Bismarck	19.4%	18.4%	19.8%	22.2%	14.1%	25.0%	18.2%	20.2%
	Region 8 - Dickinson	6.4%	6.1%	7.9%	4.7%	8.3%		6.2%	6.5%
1990 population of town in which respondent resides (grouped from zip codes)	Metro (25,000+)	36.2%	53.1%	41.8%	35.6%	27.7%	75.0%	36.7%	33.6%
	City (10,0000-24,999)	11.4%	8.2%	14.1%	9.9%	12.6%		10.9%	11.7%
	Town (2,500-9,999	5.5%	6.1%	4.5%	5.2%	6.3%	25.0%	3.5%	6.9%
	Rural (< 2,500)	44.6%	28.6%	39.0%	48.5%	47.1%		43.5%	45.8%
	Refuse	2.4%	4.1%	6%	8%	6.3%		2.5%	2.3%
Total Responses		801	49	177	365	206	4	42	461

Includes all respondents

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Q1 - Q3: By Region & Size of City

		Total	Q11. Planning region								1990 population of town in which respondent resides (grouped from zip codes)				
			Region 1 - Williston	Region 2 - Minot	Region 3 - Devils Lake	Region 4 - Grand Forks	Region 5 - Fargo	Region 6 - Jamestown	Region 7 - Bismarck	Region 8 - Dickinson	Metro (25,000+)	City (10,000-24,999)	Town (2,500-9,999)	Rural (< 2,500)	Refuse
Q1. Reaction to using tobacco funds on efforts to reduce tobacco use among kids?	Strongly favor	77.4%	76.3%	82.3%	83.6%	73.9%	73.4%	80.2%	81.9%	64.7%	80.0%	78.0%	84.1%	76.2%	42.1%
	Somewhat favor	14.7%	15.8%	10.6%	7.3%	20.2%	20.1%	11.6%	9.0%	21.6%	14.5%	12.1%	13.6%	15.7%	15.8%
	Somewhat oppose	3.2%	2.6%	2.7%		3.4%	3.8%	4.7%	3.9%	2.0%	3.4%	3.3%	2.3%	3.1%	5.3%
	Strongly oppose	2.0%		.9%	1.8%	1.7%	1.6%	2.3%	1.9%	7.8%	1%	4.4%		2.8%	
	Not sure	2.6%	5.3%	3.5%	7.3%	.8%	1.1%	1.2%	3.2%	3.9%	1.4%	2.2%		2.2%	36.8%
Q2. Reaction to using tobacco funds on water development efforts?	Strongly favor	19.2%	21.1%	24.8%	18.2%	28.6%	15.2%	17.4%	17.4%	7.8%	20.7%	20.9%	38.6%	15.1%	21.1%
	Somewhat favor	31.2%	23.7%	31.9%	32.7%	29.4%	34.8%	19.8%	30.3%	47.1%	31.4%	29.7%	29.5%	32.5%	15.8%
	Somewhat oppose	22.0%	15.8%	17.7%	16.4%	16.0%	23.9%	36.0%	23.9%	19.6%	23.4%	23.1%	6.8%	23.2%	5.3%
	Strongly oppose	14.5%	15.8%	17.7%	10.9%	16.0%	13.6%	9.3%	16.8%	11.8%	14.5%	7.7%	13.6%	17.1%	
	Not sure	13.1%	23.7%	8.0%	21.8%	10.1%	12.5%	17.4%	11.6%	13.7%	10.0%	18.7%	11.4%	12.0%	57.9%
Q3. Reaction to using tobacco funds on efforts to reduce tobacco use among adults?	Strongly favor	46.9%	31.6%	56.6%	60.0%	47.9%	43.5%	45.3%	46.5%	37.3%	50.7%	37.4%	45.5%	47.9%	21.1%
	Somewhat favor	26.8%	28.9%	21.2%	14.5%	29.4%	33.2%	15.1%	29.7%	33.3%	29.0%	29.7%	27.3%	25.2%	10.5%
	Somewhat oppose	11.5%	15.8%	6.2%	18.2%	11.8%	8.2%	22.1%	10.3%	9.8%	9.0%	12.1%	15.9%	12.6%	15.8%
	Strongly oppose	10.0%	13.2%	10.6%	3.6%	8.4%	12.0%	7.0%	11.6%	9.8%	10.3%	12.1%	9.1%	8.7%	21.1%
	Not sure	4.7%	10.5%	5.3%	3.6%	2.5%	3.3%	10.5%	1.9%	9.8%	1.0%	8.8%	2.3%	5.6%	31.6%
Total Responses		801	38	113	55	119	184	86	155	51	290	91	44	357	19

Includes all respondents

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Q4 - Q6: By Region & Size of City

		Total	Q11. Planning region.								1990 population of town in which respondent resides (grouped from zip codes)				
			Region 1 - Williston	Region 2 - Minot	Region 3 - Devils Lake	Region 4 - Grand Forks	Region 5 - Fargo	Region 6 - Jamestown	Region 7 - Bismarck	Region 8 - Dickinson	Metro (25,000+)	City (10,000-24,999)	Town (2,500-9,999)	Rural (< 2,500)	Refuse
Q4. Reaction to using tobacco funds on economic development efforts?	Strongly favor	31.2%	21.1%	30.1%	25.5%	44.5%	29.3%	31.4%	31.0%	23.5%	32.1%	22.0%	38.6%	32.5%	21.1%
	Somewhat favor	32.2%	28.9%	35.4%	40.0%	26.9%	33.7%	31.4%	31.0%	31.4%	33.8%	29.7%	27.3%	32.8%	21.1%
	Somewhat oppose	13.1%	15.8%	8.0%	7.3%	10.9%	14.7%	15.1%	12.9%	25.5%	12.1%	17.6%	11.4%	13.7%	
	Strongly oppose	14.6%	15.8%	15.0%	9.1%	15.1%	15.2%	12.8%	17.4%	9.8%	16.6%	14.3%	11.4%	14.3%	
	Not sure	8.9%	18.4%	11.5%	18.2%	2.5%	7.1%	9.3%	7.7%	9.8%	5.5%	16.5%	11.4%	6.7%	57.9%
Q5. Reaction to using tobacco funds on education funding?	Strongly favor	64.7%	68.4%	63.7%	61.8%	69.7%	60.3%	68.6%	65.2%	62.7%	62.8%	69.2%	72.7%	64.4%	57.9%
	Somewhat favor	21.5%	10.5%	25.7%	23.6%	18.5%	24.5%	22.1%	18.7%	21.6%	24.5%	14.3%	11.4%	22.1%	21.1%
	Somewhat oppose	5.7%	10.5%	4.4%	3.6%	5.0%	8.2%	3.5%	5.8%	3.9%	6.9%	3.3%	4.5%	5.9%	
	Strongly oppose	6.5%	10.5%	5.3%	5.5%	5.9%	5.0%	4.7%	9.0%	5.9%	4.8%	12.1%	9.1%	6.2%	5.3%
	Not sure	1.6%		.9%	5.5%	.8%	1.1%	1.2%	1.3%	5.9%	1.0%	1.1%	2.3%	1.3%	15.8%
Q6. Reaction to using tobacco funds to provide health insurance for uninsured?	Strongly favor	43.1%	50.0%	39.8%	47.3%	47.1%	45.3%	57.0%	43.9%	33.3%	40.9%	51.6%	43.2%	43.7%	36.8%
	Somewhat favor	31.2%	21.1%	35.4%	34.5%	31.1%	30.4%	26.7%	31.0%	37.3%	33.4%	33.0%	29.5%	29.4%	26.3%
	Somewhat oppose	12.7%	13.2%	10.6%	3.6%	9.2%	21.7%	5.8%	12.3%	15.7%	13.4%	5.5%	15.9%	13.4%	15.8%
	Strongly oppose	9.0%	13.2%	10.6%	7.3%	9.2%	9.2%	7.0%	9.0%	5.9%	9.7%	4.6%	6.8%	9.8%	
	Not sure	4.0%	2.6%	3.5%	7.3%	3.4%	3.3%	3.5%	3.9%	7.8%	3.4%	3.3%	4.5%	3.6%	21.1%
Total Responses		801	38	113	55	119	184	86	155	51	290	91	44	357	19

Includes all respondents

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Q7: By Region & Size of City

		Total	Q11 Planning region								1990 population of town in which respondent resides (grouped from zip codes)				
			Region 1 - Williston	Region 2 - Minot	Region 3 - Devils Lake	Region 4 - Grand Forks	Region 5 - Fargo	Region 6 - Jamestown	Region 7 - Bismarck	Region 8 - Dickinson	Metro (25,000+)	City (10,000-24,999)	Town (2,500-9,999)	Rural (< 2,500)	Refuse
Q7 How much of tobacco funds should be spent to reduce smoking among kids?	All of it	5.4%	10.5%	6.2%	1.8%	5.9%	4.9%	2.3%	6.5%	5.8%	7.6%	3.3%	6.8%	3.9%	5.3%
	Most of it	25.0%	10.5%	24.8%	27.3%	21.0%	29.3%	29.1%	24.5%	21.6%	27.6%	24.2%	18.2%	24.9%	5.3%
	About half	37.2%	28.9%	32.7%	38.2%	39.5%	36.4%	38.4%	43.6%	37.3%	37.2%	37.4%	45.5%	37.0%	21.1%
	Small part of it	27.5%	42.1%	31.0%	25.5%	30.3%	26.6%	26.7%	21.3%	27.5%	23.1%	28.6%	29.5%	29.7%	42.1%
	None of it	2.5%	2.6%	3.5%	1.8%	1.7%	1.6%	3.5%	3.2%	2.0%	2.8%	3.3%		2.2%	5.3%
	Not sure	2.5%	5.3%	1.8%	5.5%	1.7%	1.1%		3.9%	5.9%	1.7%	3.3%		2.2%	21.1%
Total Responses		801	38	113	55	119	184	86	155	51	290	91	44	457	19

Includes all respondents

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Demographics: By Region & Size of City

		Total	Q11. Planning region								1990 population of town in which respondent resides (grouped from zip codes)				
			Region 1 - Williston	Region 2 - Minot	Region 3 - Devils Lake	Region 4 - Grand Forks	Region 5 - Fargo	Region 6 - Jamestown	Region 7 - Bismarck	Region 8 - Dickinson	Metro (25,000+)	City (10,000-24,999)	Town (2,500-9,999)	Rural (- 2,500)	Refuse
Q8. Age.	18 to 24	6.1%		8.8%	3.6%	5.0%	7.1%	7.0%	5.8%	5.9%	9.0%	4.4%	6.8%	3.9%	10.5%
	25 to 40	22.1%	23.7%	22.1%	14.5%	21.8%	26.1%	14.0%	22.6%	27.5%	25.5%	27.5%	18.2%	19.3%	5.3%
	41 to 64	45.6%	36.8%	40.7%	40.0%	47.9%	47.8%	46.5%	52.3%	33.3%	44.8%	39.6%	43.2%	49.6%	15.8%
	65 -	25.7%	39.5%	28.3%	40.0%	24.4%	18.5%	32.6%	18.7%	33.3%	19.7%	28.6%	29.5%	27.2%	68.4%
	Refuse	.5%			1.8%	.8%	.5%		.6%		1.0%		2.3%		
Q9. Gender.	Male	42.4%	31.6%	46.9%	27.3%	40.3%	47.8%	47.7%	40.0%	41.2%	46.6%	40.7%	27.3%	41.5%	42.1%
	Female	57.6%	68.4%	53.1%	72.7%	59.7%	52.2%	52.3%	60.0%	58.8%	53.4%	59.3%	72.7%	58.5%	57.9%
Total Responses		801	38	113	55	119	184	86	155	51	290	91	44	357	19

Includes all respondents

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SENATE BILL 2380

Testimony of Lieutenant Governor
Jack Dalrymple

Mr. Chairman, members of the committee, thank you for the opportunity to comment briefly about the appropriations contained in Senate Bill 2380.

The plan contained in this bill will spend more dollars on tobacco control efforts than we have ever spent in North Dakota. Just as importantly, it will spend them on a program that is comprehensive and state-wide, using science-based programs that have been shown to be effective. This is a significant and important investment in the health of North Dakotans.

As Section 6, subsection 2, describes, there are many important components to such a program. Depending on community needs and what we see as this plan is being monitored over time, our Health Department will need to use all of these components in varying ways throughout the state.

I am concerned that the specific spending line items in Section 10 may not allow the flexibility to use each of these components in the most efficient manner. The Health Department and this advisory committee will need to respond to the changing needs of local communities and of the state as this plan is implemented.

To provide the needed flexibility, I suggest combining the two million dollars in Section 10, subsection 1(c), with the two million of subsection (d), and leaving it to the judgment of the advisory committee and the Health Department just how that will be divided between schools and communities.

Lt Gov

I also suggest combining the $750,000.00 in subsection (e) with the $250,000.00 in subsection (f), again leaving it to the judgment of the health professionals just how this should be divided between countermarketing efforts and antitobacco resource materials.

Finally, allow me to say that the administration would like to see the entire 7.2 million dollars of the trust fund and federal CDC grants devoted to tobacco prevention efforts. At this level of funding, we are right in the middle in terms of per capita spending that is done in states with successful programs. If we are going to spend this much money, let's be as sure as we can that our efforts will succeed. If we cut these funds back too much, we risk failure of this important effort.

Thank you very much, Mr. Chairman. I would be glad to answer any questions the committee may have.

HOUSE HUMAN SERVICES COMMITTEE

SENATE BILL 2380

Testimony of
Lieutenant Governor
Jack Dalrymple

March 6, 2001

Madam Chairman, members of the House Human Services committee, my name is Jack Dalrymple. Thank you for the opportunity to testify regarding Senate Bill 2380.

Darleen Bartz of the Health Department will be submitting proposed amendments and more detailed testimony later in this hearing, but allow me to introduce her testimony with comments about two aspects of this bill and an observation about an issue that was raised in the testimony this morning.

As this bill has worked through the process, the Governor has consistently supported the use of the entire 10% of the trust fund, plus the CDC federal grants, to be used for tobacco. This is the amount this body concluded was appropriate after careful consideration, and we should be mindful of those past deliberations.

This amount—approximately $5.00 per capita per year—equals about 40% of the CDC recommended amount. We need to be aware that states have been successful with programs funded at this level, and that the CDC itself has stated that no state has funded all the CDC best

practices at the full, recommended level. We can do the job with 7 million dollars for the biennium, but we must protect this money and dedicate it solely to tobacco prevention and control.

Secondly, we urge you to not tie the hands of the experts who will be implementing the CDC practices as they fit best in North Dakota. By establishing funding categories and restrictions in the legislation rather than allowing the plan itself to set those limits, we run the risk of forcing money to be spent where it should not be spent, and prohibiting spending in areas that need and deserve more funding. Please leave this bill flexible enough for the committee and the professionals to do the job according to the scientific best practices, uninhibited by artificial funding constraints.

Finally, I understand there were questions and testimony this morning that underscored the feeling that a tobacco prevention program should be driven locally, with latitude to try different approaches in different parts of the state.

It is entirely consistent with the CDC best practices to try different approaches and to establish pilot projects. Of the 7 million dollars proposed to be spent over a biennium in the type of plan the Governor supports, about 5 million dollars would go out to local entities for programs they proposed. These would be coordinated and reviewed to make sure the projects fit within a comprehensive program that works, but

local entities would develop them and propose them according to their own needs.

Ms. Bartz will propose amendments that we feel will allow a committee of experts and youth, working with the state health officer, to implement a program that works for North Dakota. I am sure she will be able to answer any specific questions you may have about those amendments. If there are questions I may answer, I would be glad to do so.

Thank you.

S.A. Dalrymple

PROPOSED AMENDMENTS TO SENATE BILL NO. 2380

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to establish a statewide, comprehensive tobacco control program within the state department of health and to establish an advisory committee.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Statewide, comprehensive tobacco control program. The amount transferred to the community health trust fund pursuant to section 25-27-25 shall be used to fund implementation of a statewide, comprehensive tobacco control program. These funds must be used to supplement the tobacco grant North Dakota receives from the center for disease control and prevention (CDC). The comprehensive tobacco control program shall be based upon the recommendations by the CDC in its 'Best Practices for Comprehensive Tobacco Control Programs', published August of 1999.

Section 2. Distribution of funds.

1. Grants may be awarded to local public health agencies or other entities upon submission of a plan for tobacco control in their community or region. The plan must include the components of the CDC's Best Practices for Comprehensive Tobacco Control Programs that the plan will implement, the local health agency and other individuals or entities involved in implementation of the plan, as well as the method for evaluating the program.

2. Any remaining funds may be used for implementation of tobacco control program components that are implemented on a statewide basis consistent with the CDC's Best Practices for Comprehensive Tobacco Control Programs.

Section 3. Advisory Committee.

1. An advisory committee is established to advise and assist the state health officer in the implementation of the statewide, comprehensive tobacco control program. The membership of the committee is as follows:

a. The state health officer or the health officer's designee.

b. Two legislative members appointed by the chairman of the legislative council.

c. The director of the department of human services or the director's designee.

d. The superintendent of public instruction, or the superintendent's designee.

e. The chairman of the Indian affairs commission.

f. Eight members appointed by the governor as follows:

(1) Three individuals between the ages of thirteen and twenty-one at the time of appointment; and

(2) Five individuals with knowledge, competence, experience or interest in tobacco control or other relevant background, including youth education, public health, social science, or business expertise.

2. Two of the individuals initially appointed under subsection (1)(f)(1) shall be appointed for a term of one year, and two of the individuals initially appointed under subsection (1)(f)(2) shall be appointed for a term of one year.

3. Except for the initial staggered terms, members appointed by the governor shall serve for a term of two years and until a successor is appointed. A vacancy on the committee must be filled in the same manner as the original appointment for the remainder of the unexpired term. All members must reside in the state.

4. The state health officer or the health officer's designee shall serve as chairman of the committee.

5. Members of the committee, other than employees of a state or local government agency (who are not members of the legislative assembly) must be compensated at a rate of sixty-two dollars and fifty cents per day and are allowed the mileage and expenses as provided by law for members of state officers and employees.

Renumber accordingly

SB 2380
3-29-01

BEFORE THE HOUSE APPROPRIATIONS COMMITTEE
SENATE BILL 2380

Testimony of Jack Dalrymple
Lieutenant Governor

Mr. Chairman, members of the committee, my name is Jack Dalrymple. I am pleased to be able to testify this morning regarding Senate Bill 2380, as it has been amended in the House.

We received the amendments to the bill yesterday and, after reviewing it, offer the following comments, which we will supplement with specific amendments that will be submitted to the committee later this morning, if that is the committee's wish.

First, let me say there is much in this bill, as amended, with which we agree. It spends 10% of the trust fund on tobacco related projects, as determined appropriate in the last session. It uses the states public health units as the local entities to administer the grants under this program, which we also believe is appropriate. It attempts to strike a balance in spending between per capita needs and statewide coverage, which we think is the right thing to do.

To ensure that the money spent will be properly accounted for and to provide for measurable results that can be brought to the legislature in future sessions, we offer the following suggestions:

1. Delete the 40-40-20 split in spending requirements that the house amendments added. We need to retain the flexibility to spend the money on practices that have been shown to work and not be restrained by categories that we find may not exactly fit.

2. Make it clear that this money will be spent on a science based tobacco control and prevention program that follows the CDC best practices, which include proper monitoring and evaluation on a statewide basis. These are the programs that are being shown to work in other parts of the country. This could include efforts to deal with other chronic diseases reasonably related to tobacco, as contained in the house amendments.

3. Give the state health officer the authority to approve the grants made under this program, selecting from those applications approved for consideration by the advisory committee. The grant proposals will still be coming from local health units, but this will make sure that, statewide, we have an effort that is comprehensive and coordinated and can be measured.

4. To make sure that all of the state is covered and can actively participate in this effort, provide that each public health unit gets a minimum number of dollars each biennium for each county it serves. This will ensure that the program is truly statewide in scope. We would suggest an amount of $10,000 would strike an appropriate balance.

5. The original emphasis of this bill was to deal with tobacco use by youth. We would suggest adding two more people of high school age to the committee to make sure these interests are well-represented.

6. Finally, limit the amount of administrative expenditures any health unit can spend to 10% of the grants it administers. We want to make sure, at all levels, that the money actually goes into programs.

Mr. Chairman, with these amendments, we feel North Dakota will have a program that can succeed and that will provide results that are measurable, so that we can continue to evaluate this effort.

Thank you.

SB 2380: Youth smoking prevention commission

A renewed focus on youth and what works.

Senator Ray Holmberg
January 31, 2001

When my daughter Mariah was in the 7th grade, she embarked on a very short lived basketball career. One event which I witnessed is appropriate to share with you today because of the parallels between what happened at one of her games and SB 2380. Valley played South Junior High. The girls were great as they set up their defense under the basket. Unfortunately, all ten players were so good at defense, AND PROTECTING THEIR TERRITORY, that no one remembered the ball. It was laying on the floor at the other end of the court. Besides seeing two middle aged male coaches come close to coronaries, the lesson I learned from this little story is that you've got to keep your eye on the ball.

There are a lot of good ideas floating around as to how the funds accumulating in the community health trust fund should be spent. These ideas are supported by sincere motives and beliefs. Some will be offensive in nature, some defensive. Your daunting task will be to sift through all of this, and come out with a bill whose primary purpose will be to have a measurable, positive, and sustainable impact on reducing the incident of youth smoking in North Dakota. That's the ball you've got to keep your eye on. A recent statewide poll supports this goal.

SB 2380 is based on model legislation published by the Council of State Governments (CSG) last year. It was developed by the CSG's Committee on Suggested State Legislation. CSG is a national organization of state policy makers including members of all branches of government. North Dakota is a member of CSG and some of you sitting on this committee may have attended some of their meetings. There were some modifications made in the model legislation to make this bill conform to style and form requirements of the legislative council, we removed references to the necessity of hiring additional state employees, and made clear that the provisions are subject to our open meetings/records laws.

This legislation puts young people in a prominent leadership position in directing tobacco settlement dollars in a concerted effort to reduce tobacco use by youth. It demonstrates that this legislature recognizes that we must deal with this problem together. "If we build it they will come," was used as a promo for the movie "Field of Dreams." I would suggest, "If we trust our young people, they will deliver." We need them as partners, not add-on's. We must allow them to do more than advise. They must be able to act on that advise by having both a voice and a vote in the process.

The health department currently supports programs on tobacco usage as does the department of public instruction though an assortment of federal funds. These programs have been around for some years, and unfortunately, have not had the kind of impact that the agencies or sponsors of 2380 would prefer. This is not to criticize their efforts. SB 2380 is a bill which has the potential to "start anew." To actually have an ongoing source of funding and a mandate to create

programs which complement and build on existing ones to reduce the number of children who begin using tobacco products. In a democracy, no program, will eradicate the experimentation by young people. This will continue no matter how sophisticated our programs are and how much money we are willing to spend. According to statistics published by the CDC in 1999, students in North Dakota who smoked cigarettes in the "past month" increased to 40.6% in 1999 from 39.6% in 1995. North Dakota is a national leader in youth smoking, not a statistic we should not be proud of in this body. We have to do better, and I believe we can.

SB 2380 appropriates money which North Dakota has received under the Tobacco Lawsuit Master Settlement Agreement from the community health trust fund, established by the 1999 Legislature. The $5,200,000 in this bill would be used to fund youth smoking prevention efforts. It establishes a grant program to be administered by an independent Youth Smoking Prevention Commission to fund such prevention efforts, including anti-smoking media campaigns directed at youth, school and community-based youth education and development programs, and increased enforcement and education of youth-access laws.

The bill provides that the commission must develop a state plan for youth smoking prevention to include criteria for evaluating grant requests as well as identify the types of programs eligible for funding. Such programs, at a minimum, should include suggestions published by the U. S, centers for disease control and prevention's best practices for comprehensive tobacco control programs, (CDC's), in addition to others which may lead to a reduction in the incidents of tobacco usage by youth. The bill requires an annual statewide student-based survey to measure cigarette use and behaviors towards cigarette use by students. In addition, reports by grantees and the commission must be provided for ongoing monitoring and evaluation of the success of the program.

The state plan will provide a multifaceted strategy that would include different types of programs directed at various aspects of young people's lives. As pointed out in the book, Adolescents at Risk: Prevalence and Prevention, a comprehensive prevention effort must be "simultaneously directed at all major social influences and institutions: schools, parents, peers, role models, media, police, courts, business, vendors of cigarettes and alcohol and youth-serving agencies."

Creation of an independent commission, housed in the governor's office, will allow persons with different expertise and backgrounds to collaborate on developing criteria to evaluate grant applications. Youth will pay a significant role in the work of the commission, along with public health experts, educators, all appointed by the governor. One-half of the governor's appointees will be youth. In addition, SB 2380 requires the commission to consider criteria recommended by experts for evaluating youth smoking prevention efforts thought media campaigns directed at youth, school-based education programs, community-based youth development programs, retailer education and enforcement of youth access prevention laws.

Accountability is provided through ongoing monitoring and evaluation and reports to the budget section of the Legislative council..

We hope that the final product of this session will be a new, statewide comprehensive plan. The grant process in SB 2380 assures that a wide variety of proposals will be considered for funding. Youth smoking is a complex problem that takes place within a matrix of societal, environmental and interpersonal influences. No single approach will solve the problem. Success is most likely to come from a variety of approaches that address as many of the factors involved as possible. In short, an effective approach to the youth smoking issue must go beyond reducing negative behavior and should include a vision of the ideals and values we want our young people to cherish and observe. Four types of programs outlined in the legislation are:

Communication programs: Mass media campaigns can play a constructive role by raising general awareness among youth and changing youth perceptions about smoking. A point made by experts is that advertising can be a helpful component of a multifaceted approach designed to enhance the effectiveness of school-based educational programs.

School-Based Education Programs: School programs can play an important role by teaching kids the social skills necessary to resist engaging in negative youth behavior such as smoking. Kids with good social skills and adequate self-esteem are better prepared to resist the urge to experiment or be influenced by their peers.

Community-Based Youth Programs: Communities can provide environments that promote positive youth development and behavior as well as delivering a strong social message about youth smoking. When communities provide social outlets that combine structured activities with strong messages about the behaviors that are socially acceptable for young people, ti tends to build resiliency among kids, to reinforce positive behaviors and to discourage negative and counterproductive activities.

Enforcement of Minimum-Age Laws: Funding for merchant education and training programs, and programs for youths who violate purchase or possession laws, should help reduce access to, and use of tobacco products by minors.

Just as I trust our young people, I also trust you, the members of the Senate Human Services Committee, to sift though the many, many suggestions you will hear over the next days. I trust that you will "keep your eye on the ball," and come out with legislation that will accomplish the goals of the sponsors of SB 2380.

SB 2380 Youth smoking prevention

Bullet points:

- Establishes a youth smoking prevention commission housed in the governor's office. Bill is based on model legislation written by the Council of State Governments. All funding comes the community health trust fund.

- Puts young people in a prominent leadership position in directing tobacco settlement dollars to reduce tobacco use by youth.

- $5,200,000 appropriated in the bill for the program. No more than 5% may be used for administration of the program.

- Governor appoints ten commissioners, five of them must be between ages of 13 - 18. Two members appointed by legislative council. Governor or his designee is also a member and chairs the commission. One of commission member would represent Native American interests.

- "Tobacco use prevention program plan must be sustainable, long-term, comprehensive, and utilize components of the centers for disease control and prevention's best practices. The plan must build on and must not duplicate current programs."

- State plan published for public comments.

- Grants awarded to a variety of community/school organizations focusing on reducing the incident of smoking by youth.

- Accountability is an important component of the program. As policy makers, we want to know that it works.

SB 2380 Youth smoking prevention

Senator Holmberg
House Human Services Committee, March 6, 2001

- Bill is based on model legislation written by the Council of State Governments, Interim Legislative committee, plus input by sponsors, Gov.'s office, legislative leadership, and the hard work of our Human Services and appropriations committees.

- Establishes a tobacco prevention advisory committee housed in the governor's office. Funding comes the community health trust fund and federal anti-smoking grant moneys from the Centers for Disease Control. State health officer is fiscal agent for the funds.

- $7,100,000 appropriated for the program; the funding is found in the Health Department budget, SB 2004

- 12 member committee, including Gov. AG, DPI, state health officer, native American representative, 2 legislators, one "youth", academic researcher, physician, public health community representative, and a non-governmental tobacco control organization representative.

- State plan developed and published for public comments.

- Bill provides that "Tobacco use prevention program plan must be sustainable, long-term, comprehensive, and utilize components of the centers for disease control and prevention's best practices. The plan must build on and must not duplicate current programs."

- Funding awarded to a variety of community/school organizations focusing on reducing the incident of smoking by youth.
  a. $1 million as state aid to local public health units
  b. $4 million for healthy schools and healthy communities grant for school tobacco cessation programs. Communities grant requires local matching funds and must focus on reducing incidents of youth tobacco usage.
  c. $1 million for statewide counter-marketing media and materials to the public.
  d. Balance of the appropriation for public health emergencies and grants. Money cannot be used for political activities

- Accountability is an important component of the program. As policy makers, we want to know that it works.

- Additional issues requiring further work and refinement.
  Number of youth on the committee
  Role of the state health officer
  Proper funding mix.
  How the drug free schools money(which includes tobacco issues) fits into a coordinated tobacco control plan. $570,000 in the human service budget and the over $1 million in DPI's budget,

TO: Chairperson Price and Members of the House Human Services Committee

FROM: Ray Holmberg, Senator
Joel Heitkamp, Senator

DATE: March 12, 2001

RE: SB 2380 and Youth Involvement

We would respectfully disagree with the tenor of the letter provided to your committee by Ms. Linda Johnson, Director of School Health Programs for the Department of Public Instruction. Ms. Johnson relates her concerns regarding SB 2380 and the desire of the bills sponsors to assure real, meaningful involvement by young people.

Apparently, as people who work with youth every day, one of us as a parent and the other as a high school counselor, we have developed a different regard and respect towards the abilities of our young people, in contrast to the attitude this letter appears to suggest. In the real world where we work, there are many young people who would not "feel pressure to go with an underlying current of the decision in the room." They are as outspoken as any person who may serve on the committee contemplated in the bill. To suggest otherwise shows a disconnect with that real world within which SB 2380 is designed to work.

Please join us in trusting young people to be more than "window dressing" as we try to deal with the real problem of tobacco usage by teenagers.

cc. Dr. Wayne Sanstead

ND Legislative Assembly

John M. Andrist'
State Senator · District 2
P.O. Box E
Crosby, ND 58730

Phone: 701-965-6798
Office: 701-965-6088
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Testimony SB 2380
Presented by John Andrist

I have gone over this bill a number of times, and am very supportive of it, but I want to share with you some issues that I think you should consider for possible amendment, inasmuch as this is landmark legislation.

1. One of the most unique concepts is bringing youth into the discussion, but I'm wondering if 13 isn't too young and if the upper limit should be 20 or 22.

2. On page 2, line 26: I can't understand why this line is in the bill. As I read the bill they would not be custodian for the funds, and thus would not have funds to invest.

3. On page 2, line 30: Should the bill more clearly state that the Governor's designee will chair the committee, call the meetings, and preside over them?

4. On page 4, beginning on line 10 with, "The eligible . . . through line 21. It seems to me that this part unduly restricts the flexibility of the commission. I would hope you would take more time to reflect on this. If we are going to have a blue ribbon commission let's not limit their scope and imagination.

5. On page 6, lines 24 to 26, I think continuing appropriations are bad policy, and I have consulted our leader who feels even more strongly. I would suggest you remove these lines.

6. The word "smoking prevention" appears in a number of places. One health professional believes tobacco prevention is better, more flexible terminology. Chewing is also dangerous. I think she is right.

My overriding concern is that the bill is too limiting in scope, dealing only with youth and with smoking. In addition to the $5.2 million in the bill, there is a possibility we can roll another $2 million in federal funding allocated to the Department of Health. I have some concern that we really can't wisely spend this amount of money on such a narrow focus?

A $50,000 grant is a whale of a lot of money to spend in one school district. $6 million represents 120 $50,000 grants. Stated another way, it represents more than $25,000 for every school district in the state.

I wonder if we shouldn't broaden the program to open public health districts to develop smoking cessation programs targeted at all smokers, and not confined to youth.

And finally, I can visualize that schools might devise some imaginative programs encompassing a number of youth risk behaviors such as alcohol, drugs, and sexual activity. Might we want to make these programs eligible for grants? If so I would think it appropriate, wherever youth smoking appears, to substitute "tobacco use and other youth risk behaviors".

Again, I support the bill and trust you will give some consideration to these suggestions.

Prepared by the North Dakota Legislative Council
staff for Senate Appropriations
February 20, 2001

ANALYSIS OF THE COMMUNITY HEALTH TRUST FUND FOR THE 2001-03 BIENNIUM (REFLECTING THE STATUS OF BILLS AS OF FEBRUARY 19, 2001)

Estimated beginning balance - July 1, 2001		$5,232,532[1]
Add estimated revenues		
Estimated transfers from the tobacco settlement trust fund for the 2001-03 biennium	$5,307,289[2,3]	
Total estimated revenues		$5,307,289
Total available		$10,539,821
Less estimated expenditures as of February 19, 2001		
Tobacco prevention and control (Senate Bill No. 2004)	$4,700,000	
Metabolic diseases (Senate Bill No. 2004)	80,000	
Donated dental services program (Senate Bill No. 2004)	35,000	
Dentists' loan program (Senate Bill No. 2276)	180,000	
Breast and cervical cancer medical assistance (House Bill No. 1472)	114,755	
Total estimated expenditures - 2001-03 biennium		$5,109,755
Estimated ending balance - June 30, 2003		$5,430,066

[1] The estimated July 1, 2001, balance at the end of the 1999 legislative session was $5,759,376. The decrease in the estimated balance of $526,844 is due to a decrease in the amount of tobacco settlement payments estimated to be received.

[2] As of February 2001, eight transfers have been made from the tobacco settlement trust fund to this fund totaling $3,796,778.

[3] Estimated revenues - Interest earned on the community health trust fund is not included in the analysis as the law does not allow the community health trust fund to retain interest earned. Any interest earned by the community health trust fund will be credited to the state's general fund.

FUND HISTORY

The community health trust fund was created by the 1999 Legislative Assembly through passage of House Bill No. 1475. This bill creates a tobacco settlement trust fund for the deposit of all tobacco settlement moneys obtained by the state. Moneys in the fund must be transferred, within 30 days of their deposit in the fund as follows:

- Ten percent to the community health trust fund.
- Forty-five percent to the common schools trust fund.
- Forty-five percent to the water development trust fund.

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Anti-smoking funds sparse Despite a $250 billion tobacco lawsuit windfall, only a few states are using the money to fight teen smoking. However, those that try are coming up big.

By Anthony DeBarros
USA TODAY

When Mississippi's governor signed House Bill 641 last May, making it illegal for anyone, including teachers, to use tobacco in public schools, it was a major victory for the state's newest anti-smoking warriors: a teen advocacy group called Frontline.

Funded by the state's settlement with tobacco companies in 1997, the teens had pressed lawmakers during a rally on the state Capitol steps earlier in the year.

"We didn't think it was right for a teacher to tell students, 'You shouldn't smoke,' and then run around to the teacher lounge in between classes and have a cigarette," says Seth Bassett, a high school senior from Jackson, Miss., and Frontline's state co-chairman.

The legislative victory -- as well as data showing smoking declines as steep as 21% among youth in Mississippi -- are among the payoffs that state officials attribute to the launch of a comprehensive anti-tobacco campaign using $62 million from its settlement with cigarette makers.

Mississippi's success, however, is overshadowed by a far gloomier picture nationwide. The states are to receive about $250 billion over 25 years from the landmark settlement with cigarette manufacturers about three years ago.

However, only about 8% of the initial payments is being used to fund anti-smoking efforts, according to Thomas Houston, director of the SmokeLess States National Program Office at the American Medical Association.

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Moreover, only six states are spending -- either with settlement money or other funds -- what the Centers for Disease Control and Prevention considers the minimum for an effective anti-smoking program, according to a report released this month by the Campaign for Tobacco-Free Kids.

Across the USA, legislatures are battling over where to direct the windfall. So far, with no restrictions on how the money is spent, states have heard proposals ranging from cutting taxes to cleaning up strip mines. "Most of the states have not put in the critical mass (of money) recommended by the CDC," says John Seffrin, CEO of the American Cancer Society. "I worry that some of those states will give (anti-smoking programs) a lick and a promise and say it doesn't work."

Messages for teens

The concern comes at a critical time for efforts to help teens stop lighting up -- or to stop them from ever starting. In 1999, about 35% of high school students were smokers, according to the CDC, up from 28% in 1991. Still, anti-smoking advocates see several glimmers of hope: a leveling off nationally between 1997 and 1999, and sharper drops in several states that suggest anti-tobacco forces have finally discovered how to craft a message that adolescents will heed.

Some states, such as Mississippi, Florida and Minnesota, are spending millions from their settlements on youth groups, education and, in perhaps the most visible aspect of the new war on teen smoking, edgy TV ads with a pointed message: Big tobacco wants to manipulate you, kid.

Drawing on adolescents' penchant for rebellion, campaigns such as Mississippi's "Question It," Florida's "truth" and Minnesota's "Target Market" portray tobacco companies as sinister authority figures. "Their brand is lies," Florida ads say. "Our brand is truth."

The messages apparently resonate. In Florida, smoking is down 40% among middle-school students and 18% among high-schoolers since the state began an anti-smoking campaign with tobacco settlement money in 1998, according to the Department of Health. "The figures are impressive," says Debra Bodenstine, director of the Division of Health Awareness and Tobacco. "They're not the norm."

In Mississippi, which has used its tobacco settlement to promote a comprehensive anti-smoking effort since 1999, smoking dropped 21% for middle school and 10% for high school students between 1999 and 2000, according to the Mississippi Department of Health.

Other states with longer-running programs funded by cigarette taxes, such as California and Massachusetts, also report declines.

"Any time we can, from a social marketing standpoint, stop a trend, it's huge," says Jim Audette, director of Minnesota's "Target Market" program, which launched last year. "What Florida did was reverse a trend in just two years. I've never seen that before."

However, states making strides are in the minority, as are those devoting big money to the problem.

The settlement in November 1998 between tobacco companies and 46 states netted $206 billion, ostensibly to recover tobacco-related disease costs. Four other states -- Florida, Minnesota, Mississippi and Texas -- negotiated an earlier, separate settlement of $40 billion.

But according to the non-profit Campaign for Tobacco-Free Kids, only 15 states have made a "substantial" commitment to fund smoking prevention programs using their tobacco settlement money -- spending at least 50% of the minimum funding recommended by the CDC for an effective program. Only six states are spending the minimum.

An additional 12 states have committed "modest" funding -- less than half the amount recommended by the CDC. The rest of the states have set aside minimal funds or none at all.

Michigan, for example, has allocated none of its settlement money for anti-smoking programs. Instead, it plans to spend the bulk of its $8 billion share on college scholarships and for research in genetics and biotechnology.

"We figure that we've already paid for the costs associated with smoking through our general fund or other state budgets at the sacrifice of other programs," says John Truscott, a spokesman for Michigan Gov. John Engler. "Now that this pot of money becomes available, we're putting it into programs (that were sacrificed)."

In South Dakota, where nearly 44% of teens smoke, Gov. Bill Janklow wants to use the state's share of the settlement -- about $25 million a year -- on a college scholarship program. The state placed its initial payments in a trust fund, allocating $700,000 in interest to a smoking cessation program.

"There's a disconnect," says Michael Moore, the Mississippi attorney general who brought the first state lawsuit against the tobacco companies and has lobbied lawmakers in 30 states. "There are people making the decisions about the money who weren't involved in the litigation. They know very little about it, and they don't feel like they're part of the mission."

Speaking the language

the ones doing battle with a new weapon: MTV-style counter-marketing.

Rather than wag fingers at kids, they pit them against the perceived evil of big tobacco. "You target us, we target you" is a tag line on some ads in Minnesota. In one TV spot, kids hold up signs: "Tobacco companies have a strategy. Start them early. Tell them it's cool. And keep them addicted. Why? They gotta replace the dead ones."

No numbers have emerged yet to gauge the effectiveness of the program, which kicked off last spring. But few question its necessity. A Minnesota Department of Health survey in 1998 found that 42% of 12th graders smoked cigarettes in the past 30 days, up from 31% in 1992.

"It allows youth to legitimately lead the movement," says Audette, of Minnesota's Target Market. "It takes out the piece that's killed tobacco prevention in the past, and that's preachiness."

The in-your-face approach, most experts agree, was born in Florida. After settling its lawsuit against cigarette makers in 1997, the state launched a pilot tobacco prevention program. One of its first efforts: Talk to teens. It held a youth summit in March 1998, drawing 600 children from across the state.

"We basically fell on the strategy of, 'We don't have the answer, so let's ask kids,'" says Chuck Wolfe, a former director of the Florida Tobacco Pilot Program who went on to help launch the American Legacy Foundation, a national anti-tobacco group funded by the tobacco settlement. "They said, 'We're tired of hearing health messages. Everybody knows tobacco is bad for you.' That was like a light going off for us."

It was at the summit that the first television ads in Florida's "truth" campaign were filmed. One shows a girl wearing a ski mask, reading a list of demands to the tobacco industry as if she were a terrorist. "The other," Wolfe says, "is 600 kids in a field, waving at the tobacco industry. They all waved in one motion and said, 'Hi.'"

Both were designed to send a message on behalf of Florida teens: We're here, big tobacco, and we want you to listen to us.

"They speak to teens in teens' own voice," Wolfe says.

Others have followed Florida's template. In Mississippi, a "Question It" radio and TV campaign features a spot in which tobacco company executives laugh and pat each other on the back as a lab monkey goes through nicotine testing -- as though they take sinister pleasure in addicting the animal.

"They (teens) needed to understand that smoking was actually an

expression of conformity," says Eric Hughes, creative director at Mars, West & Baker Advertising Communications, the Mississippi ad agency that crafted the spots. "You're doing what a company wants you to do, for their benefit."

Nationally, the American Legacy Foundation -- funded with about $1.5 billion of the settlement negotiated by the 46 states -- has run its own "truth" ads on radio and TV. They include the controversial body-bag ads shown during the Sydney Olympics. One ad, which parodies the cowboy image of the Marlboro Man, shows teens herding horses carrying black body bags. The tag line: "What if cigarette ads told the truth?"

Education and enforcement

However, the programs rely on more than advertising. In August 1999, the CDC recommended that states establish comprehensive tobacco control efforts that include education in communities and schools, cessation programs and greater enforcement of laws.

Florida, for example, enacted a law in 1998 that allows courts to suspend the driver's license of anyone under 18 caught with tobacco. The state stepped up community efforts, including teen-led "SWAT" teams -- Students Working Against Tobacco -- in each of its 67 counties. The teams spread the anti-smoking gospel among youth, leading sessions at community centers, holding rallies and, in one county, having a beach cleanup at which kids picked up 50 pounds of cigarette butts and other refuse.

But if Florida is a pattern for success, it's also an example of these programs' tenuous existence. After the program received $93.2 million in its first two years, lawmakers tried to cut all funding for 2000 before agreeing to spend $44 million. The cutback led to the elimination of 10 staffers and a reduction in radio and billboard ads, says program director Debra Bodenstine.

"It's just going to be up in the air every year," says Christine Ortiz, 18, who lobbied lawmakers for funding in 1999 while she was a high-schooler in Longwood, Fla. She now studies at MIT in Boston and speaks on tobacco issues for the American Legacy Foundation's "truth" program.

Danny McGoldrick, research director at the Campaign for Tobacco-Free Kids, says programs in other states also remain in doubt. Montana, Virginia, Maryland and Maine, for example, all are facing legislative challenges to their anti-smoking spending, he says. Mississippi, conversely, not long ago guaranteed $20 million a year for The Partnership for a Healthy Mississippi, which runs Frontline and other efforts.

"With the states, the big concern I have is, 'What's going to happen next

year?' " says Gregory Connolly, who directs the program in Massachusetts. "Three years ago, all we heard states say was, 'We're suing for the kids.' Then they turn around today and say, 'We sued for the money.' If that's what we did, we had no right being in the courtroom in the first place."Cover storyCover story



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It's too early to give up on our anti-tobacco campaign

Sunday, December 31, 2000

The Daily Herald – Everett, WA

By Steven M. Guyton, M.D., Dennis W. Biggs, Jr., M.D. and Robert Jaffe, M.D.

When Fred Hutchinson Cancer Research Center researchers announced last week that a statewide school-based anti-tobacco campaign failed to reduce teen smoking, it merely confirmed what many of us on public health's front lines have long regarded as the truth:

That the only way to combat tobacco use in our society is with a comprehensive, sustainable program that includes counter-advertising campaigns, community-based programs, quit-lines, tough youth access laws, smoke-free schools and assessment evaluation.

Up until this year, Washington state has never had a tobacco prevention and control program combining those elements. Not even close. In fact, over the 15 years that Fred Hutchinson researchers followed students here, our state spent virtually no money on anti-tobacco campaigns beyond a small amount put into the schools. At the same time, pioneering states such as California and Massachusetts were putting together comprehensive programs that yielded dramatic results in driving down teen smoking, cancer rates and smoking among pregnant women.

Washington state tried to combat smoking on the cheap and the extent of our failure is reflected in these study results.

The surprise is that anybody is actually surprised by this revelation.

But things are about to change in Washington. We are in line to receive as much as $4.5 billion over the next 25 years from the landmark national tobacco settlement. Lawmakers appropriated $15 million this year to fund the sort of comprehensive, sustainable tobacco prevention and control program that has worked so well in other states.

The Washington chapters of the Heart Association and the Cancer Society and the Washington Alliance for Tobacco Control and Children's Health are frankly excited about this evolution in philosophy, one that we have advocated for years now. And we salute tobacco control champions such as Governor Gary Locke, Attorney General Christine Gregoire, House co-speaker Frank Chopp and Secretary of Health Mary Selecky. They fought -- and are continuing to fight -- to ensure that tobacco settlement dollars went to tobacco control while other politicians eye the money for roads, among other things.
Our state's tobacco prevention and control program is already going forward on several fronts.
A tough anti-smoking counter-advertising campaign aimed at blunting the $100 million in advertising the tobacco industry spends annually in Washington state is underway. A toll-free "Quit Line" run by cessation experts at Group Health Cooperative was inaugurated two months ago. Campaigns aimed at such high-risk groups as pregnant women, Native Americans, Asians and Pacific Islanders have begun. The state Department of Health is targeting communities and towns where tobacco use has reached almost epidemic proportions, particularly rural areas in southwest and northeast Washington.

Washington state's tobacco prevention and control plan is still in the toddler stage, less than a year old. But with continued political and community support we believe that results such as those achieved in neighboring Oregon will soon be realized. Recently Oregon officials revealed that 41 percent fewer eighth graders smoke now than did so four years ago, a decrease that nearly doubles the national average.

The dramatic decrease happened because Oregonians set in motion a comprehensive, sustainable tobacco control and prevention program with the passage of a 1996 state initiative. Unlike the isolated school-based effort here, the Oregon program is broad-based and has an ongoing funding base. In California, where a comprehensive program has been in place since 1986, the results have shown that over a ten-year period there were 33,000 fewer deaths from heart disease related to tobacco use.

The fight will begin this January in Olympia over how tobacco settlement dollars will be spent. Governor Locke wants the program to get an additional $30 million over the next two years, but already opponents are stirring, emboldened at least in part by the headline-producing Fred Hutchinson study.

When the Fred Hutchinson researchers are called to Olympia to testify, we hope they will remind legislators that their work only looks at one slice of tobacco control.

In the meantime, Washington state is now able to embark on the sort of tobacco prevention and control program that produced results like those achieved in California, Massachusetts and Oregon. The Washington chapters of the Heart Association and the Cancer Society and the Washington Alliance for Tobacco Control and Children's Health enthusiastically endorse these efforts and will work at the state Capitol to ensure they move forward.

With continued public support, Washington's tobacco prevention and control program will save lives and money.

Steven M. Guyton, M.D. is the president of the American Heart Association, Northwest Affiliate. Dennis W. Biggs, Jr., M.D. is the President of Tobacco Free Spokane County and a Board member of the Spokane Unit of the American Cancer Society. Robert Jaffe, M.D., represents the Washington Alliance for Tobacco Control and Children's Health.

SB 2380
3-29-01

Factors Associated with Cigarette Smoking ▲ = Risk ● = Protective

	Males			Females		
	White[2]	Black	Hispanic	White[2]	Black	Hispanic
Individual Level						
Frequent problems with school work	▲	▲	▲	▲	▲	▲
Frequently just hangs out with friends	▲	▲	▲	▲	▲[5]	▲[5]
Frequenty religious activities		●	●			
Frequency of hobbies					●	
Work 20 hrs/wk during school*	▲					
Degree of physical maturity		▲	▲			▲
Rape/sexual abuse history*		▲		▲	▲	▲
Youth has bad temper*		▲			▲	▲
Degree of self-esteem		●	●			
Wants & expects to attend college		●	●			
Peer Context						
Number of best friends who smoke	▲[4]	▲[5,6]	▲[6]	▲[4]	▲[4]	▲[4,6]
Prejudice among students at school					▲	
Family Context						
Smoker in the home*	▲[4]	▲		▲[4]		▲[4]
Teen sets his/her own curfew*					▲	
Positive parent/family relationship)						

* A dichotomous (yes/no) variable. History of rape was asked only of females. History of sexual abuse was defined as first intercourse before age 12

[1] The following risk and protective factors were not associated with amount of smoking in any gender/ethnic subgroup: ever repeated a grade; physical recreation; extent of religious beliefs; belief that successes were earned; family member suicide or attempt; presence of extended family in the home (youth, adult); whether Spanish was primary language at home (Hispanic); parent present at dinner; parent presence after school; number of siblings; extent of joint parent-youth decision making.

[2] The following risk and protective factors were treated as non-significant for Whites in the table because they were not consistently related to smoking among White youth when their sample size was matched to the Hispanic and Black sample sizes: religious activities; hobbies; physical maturity; temper; history of sexual abuse; belief that successes were earned; parent-family relationship; parent-presence at dinner; number of siblings; friend suicide or attempt

[4] Risk enhanced by friends smoking.

[5] Risk enhanced if there is a smoker in the home.

[6] Risk enhanced by just hanging out.

[7] Risk enhanced by low self-esteem.

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3-29-01

VITAL*SIGNS*

"Best Practices": Nine Components of Comprehensive Tobacco Control Programs

I. Community Programs
- Engage youth in developing/implementing interventions
- Develop partnerships with local organizations
- Conduct educational programs
- Promote government/voluntary policies (clean indoor air, youth access, treatment coverage)

II. Administration/Management
- Facilitate coordination of program components
- Involve multiple state agencies (e.g., health, education and law enforcement) and local government
- Partner with statewide voluntary health organizations and community groups
- Prepare and implement contracts
- Provide fiscal and program monitoring

III. School Programs
- Tobacco
- Evidence
- Teacher
- Parent
- Cessation
- dents

IV. Statewide Programs (technical assistance to local programs)
- Evaluate programs
- Promote media advocacy
- Implement smoke-free policies
- Reduce minors' access to tobacco

V. Chronic Disease Programs
- Focus attention on tobacco-related diseases to prevent them and to detect them early
  - ✓ Cardiovascular disease
  - ✓ Asthma
  - ✓ Oral health
  - ✓ Cancer

VI. Counter-
- Paid TV
- and
- Ma
- health
- Effort
- tobacco
- stra

VII. Surveillance and
- Monitor program
- Youth
- Tobacco-
- Attitudes
- Health out

VIII. Cessation Programs
- Brief advice by medical providers, counselors and pharmacotherapists
- System changes such as tobacco-use screening systems and clinician train-
- Insurance-based treatment programs
- Quitline telephone cessation helplines
- Coverage of treatment of tobacco use
- Medicaid, public and private insurance
- Reduction of cost barriers to treat-
- For underserved populations

North Dakota Legislative Assembly

North Dakota Legislative Assembly
Rep. William R. Devlin
Box 475 4th Street
Finley, ND 58230-0475

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March 29, 2001

Good morning Chairman Timm and members of the House Appropriations Committee. For the record, I am Rep. Bill Devlin of District 23.

I welcome the opportunity to echo the comments of chairman Price and urge a do pass of SB2380 as amended.

SB2380 has been a work in process since we started working on this program in the Interim.

The bill as amended by House Human Services uses an approach that is consistent with all the testimony by CDC experts. The bottom line indicates that the only plan that will work is a local one.

We want the experts in the Department of Heath and the Community Heath Grant Program Advisory Committee to bring fourth the specific criteria for the grant application process but the effort must be made at the local level, if it has any chance of success.

That is consistent with not only the recommendations of the CDC experts but the position that the Hoeven administration has taken. Lt. Governor Dalrymple in testimony on March 6th said the administration supported a plan that would see over 5 million dollars going out to local entities for programs they proposed. The Lt. Governor went on to say that local entities would develop them and propose them according to their own needs.

We agree with that statement. The programs can't be dictated by Bismarck but must be a grassroots effort that allows local schools, cities, counties public heath districts and other local entities to design a plan that is best for their area of the state.

Rep. Devlin

One thing that we have learned over the years in our state is that one size does not fit all. What works for Finley may not work for Bismarck or Minot. Each area of the state must have the ability to design what is best for them. SB2380, as amended, does exactly that.

It also consistent with the Blue Ribbon Tobacco Panel that repeatedly sited the need for a state effort tied to strong local effort. They talked about the importance of strengthening existing and developing new coalitions representative of the diverse population of the community in every county or cluster of counties in the state.

CONT

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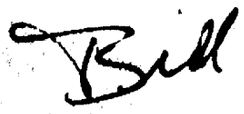
Make no mistake, SB2380 will take our anti-tobacco fight into every county, city, school and Public Heath agency in the state. It will involved young people working with their peers and adults in every community to control tobacco use every where. I want to praise the work of Senator Holmberg, who has been the leading advocate in this state of involving the young people of our state in this effort. SB2380, as amended, will build on Senator Holmbergs efforts at a state level and expand it to include young people in every community. I want to publicly thank him for leading these efforts.

SB2380 ,as amended, allows us to work with the Public Heath Agencies that serve the people in every county of our state to insure that we win the war on tobacco use in North Dakota. We don't have to reinvent the wheel but instead can strengthen the local entities that are already working to improve the health of every one of our citizens, by providing the dollars needed to successfully control and stop the use of tobacco in our state.

SB2380, as amended, will implement a statewide comprehensive tobacco control program in every area of our state. To do any less would be a great disservice to all of our people. I urge this committee to give this amended bill a do pass recommendation, send it to the house floor for our approval, on conference committee and to the governors desk for his signature.

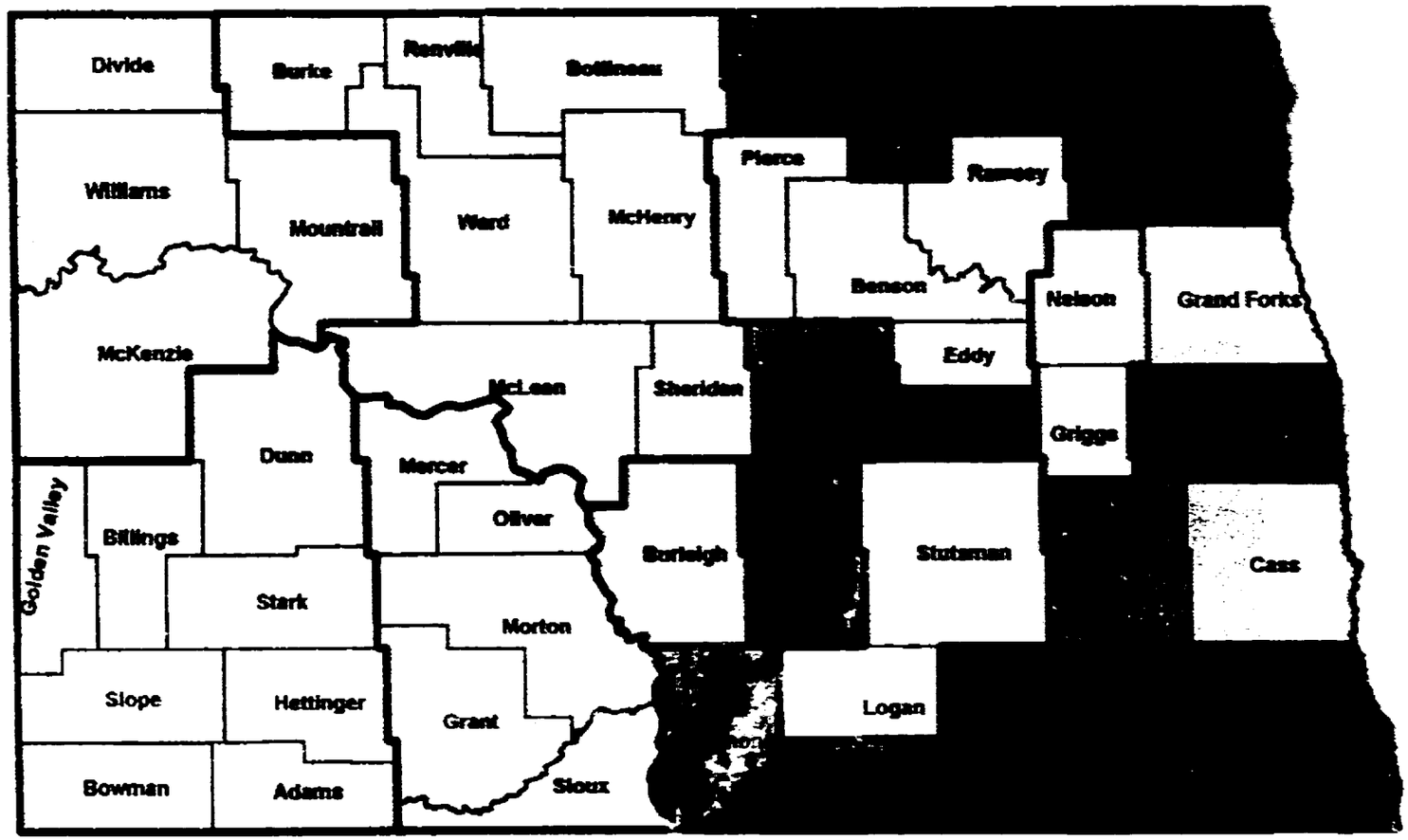
Chairman Timm, and committee members, that concludes my testimony. Thank you for allowing me to be here this morning.

Sincerely yours,



William R. Devlin
State Representative
District 23
Finley, ND 58230

North Dakota Local Public Health Units



Multi County Health District

Single County Health District

City/County Health Department

City/County Health District

Single County Health Department

December 2000

SB 2350
3-29-01

Center for Disease Control Tobacco Prevention Contracts
For the Period July 1, 1999 through June 30, 2001
As of March 19, 2001

Vendor	FY 2000	FY 2001	Total Biennium
Bismarck Burleigh Nursing Service	$ 35,000.00	$ 50,000.00	$ 85,000.00
Central Valley Health Unit	35,000.00	50,000.00	85,000.00
City-County Health Department	58,000.00	71,832.00	129,832.00
Custer District Health Unit	34,955.73	50,000.00	84,955.73
First District Health Unit	35,000.00	50,000.00	85,000.00
Grand Forks Public Health Dept	34,782.68	50,000.00	84,782.68
Lake Region District Health Unit	32,265.31	32,480.00	64,745.31
Red River Health Promotion	60,812.68	24,187.32	85,000.00
Richland County Health Department	35,000.00	52,400.00	87,400.00
Southwestern District Health Unit	14,360.18	36,132.00	50,492.18
Spirit Lake Sioux Nation (Devils Lake)		6,000.00	6,000.00
Standing Rock Tribal Health		6,000.00	6,000.00
Three Affiliated Tribes		6,000.00	6,000.00
Trenton Service Area		6,000.00	6,000.00
Turtle Mountain Band of Chippewa	19,933.72	20,000.00	39,933.72
Upper Missouri District Health Unit	35,000.00	50,000.00	85,000.00
	$ 430,110.30	$ 561,031.32	$ 991,141.62

562380
3-2901

Tobacco 01-03 Budget Schedule

Salaries & Wages	
1 #247 Prom, Jeanne	91,440.00
0.5 #018 Vacant	42,658.00
1 #116 Ebach, Colleen	54,103.00
1 #309 Vacant	92,139.00
1 #310 Vacant	86,775.00
4.5 Total Salaries and Wages	$367,115.00
Miscellaneous Operating Expenditures	$10,244.00
Educational Supplies	$30,000.00
Travel	$45,000.00
Operating Fees & Services	
Tobacco - Training and Evaluation	148,000.00
Tobacco - DH Research	16,000.00
Tobacco - Advertising	200,000.00
Tobacco - Vision Technology	8,000.00
Tobacco - Macro International	8,000.00
Tobacco - Roughrider Health Prom.	20,000.00
Total Operating Fees & Services	$400,000.00
Professional Services	
Legal	6,000.00
Tobacco - Quit Line	34,000.00
Total Professional Services	$40,000.00
Equipment	$12,575.00
Grants	
Local Public Health Units/Tobacco Coalitions	1,395,000.00
Tribal Organizations	100,000.00
Total Grants	$1,495,000.00
Grand Total	$2,399,934.00

CENTERS FOR DISEASE CONTROL AND PREVENTION'S BEST PRACTICES FOR A COMPREHENSIVE TOBACCO CONTROL PROGRAM BUDGET

CDC Best Practices	Range of Estimated Biennial Cost	Proposed Budget	% of Minimum Best Practices Estimated Biennial Cost
Community Programs, including: ◆ Chronic Disease Programs, and ◆ School Programs	$10,170,000 - $16,284,000 (62.2%) (49%)	$1,465,000(CDC) + $3,700,000 (Settlement) Total = $5,165,000 ($129,433 = Salary/Fringe School Health & Epidemiologist)	51% (70% of total funds)
Enforcement	$852,000 - $1,634,000 (5.2%) - (5%)	$0	0%
Statewide Programs	$514,000 - $1,282,000 (3.2%) – (4%)	$220,332	42.9% (3% of total funds)
Counter-Marketing Programs	$1,282,000 – $3,846,000 (7.9%) – (12%)	$549,453	42.9% (7.5% of total funds)
Cessation Programs	$1,374,000 - $5,730,000 (8.4%) – (17%)	$588,799	42.9% (8% of total funds)
Surveillance and Evaluation	$1,420,000 - $2,906,000 (8.7%) – (9%)	$608,668	42.9% (8.3% of total funds)
Administration	$710,000 - $1,440,000 (4.4%) – (4%)	$237,682	33.5% (3.2% of total funds)
Total	$16,322,000 - $33,282,000	$7,369,934	(100% of total funds)

SB 2260
3-29-01

	Payments prior to 2001	1/1/2001 Payment	4/15/01-4/15/03 Payments	Total
Total	$ 39,664,737.60	$ 6,012,813.34	$ 99,783,553.00	$ 104,781,103.83
[illegible] 50% fund	$ 5,939,472.79	$ 991,991.92	$ 9,979,366.99	$ 16,476,110.36
[illegible] trust fund	$ 13,479,631.56	$ 3,009,796.89	$ 30,657,009.12	$ 47,142,466.72
[illegible] funds	$ 13,479,631.56	$ 3,009,796.89	$ 30,657,009.11	$ 47,142,466.72
TOTAL				$ 104,781,103.83

Available 4/01 pay date	MSA amount	MSA volume adjusted payment (Amount-15.34%)	Payment after inflation 3% adjusted
4/15/01	$ 19,822,364.19	$ 15,884,446.96	$ 13,971,373.89
[illegible]	$ 9,699,978.66	$ 8,139,466.32	$ 8,139,466.32
4/15/02	$ 20,329,649.32	$ 17,033,772.41	$ 16,162,786.89
1/15/03	$ 9,699,642.16	$ 8,979,298.57	$ 8,979,298.57
4/15/03	$ 20,329,649.32	$ 17,033,772.41	$ 16,162,786.89
total	$ 77,164,532.79	$ 66,329,994.83	$ 99,783,553.00

*Assumes an 15.34% volume adjustment and a 3% inflation increase
No adjustment for market share loss (SPM)

TESTIMONY TO N.D.SENATE APPROPRIATIONS COMMITTEE
Feb. 19, 2001
Sharon E. Buhr, MPH, LRD

Thank you listening and considering my testimony today.

I'm Sharon Buhr from Valley City. I have several different reasons for being deeply concerned about the price in lives and dollars that we are paying because of tobacco addiction. For the past five years, I have been president of the Valley City School Board; I have a Master's Degree in Public Health and am a Licensed Registered Dietitian. I am the director of the Young People's Healthy Heart Program, which I created 20 years ago; the entire focus of this program is the prevention of heart disease. I have been a member of the City-County Public Health Board for 10 years. Today I'm also representing my husband, Dr. James B. Buhr, a family practitioner at MeritCare in Valley City.

The views I'm expressing today are the same views expressed by my husband and six other concerned doctors when they held a press conference on Feb. 8 urging the State Legislature to put $8.2 million of the state's tobacco settlement money each year into reducing tobacco use. We are pleased that Senate Bill 2380 establishes and implements a **sustainable, comprehensive, science-based tobacco prevention and dependence treatment plan.** But North Dakota won't get an effective program with the [illegible] amount of money provided in this bill.

The key question is: Why does this program have to cost North Dakota $8.2 million PER YEAR?

The CDC has determined $8.2 million per year is the minimum amount North Dakota must invest in order to achieve a truly comprehensive program. The CDC (U.S. Centers for Disease Control) is not "Washington DC" – it isn't political. They are the nation's top scientists, doctors, and researchers in the field of health. They are the experts we all count on when we want help in preventing and controlling all kinds of deadly diseases -- for example, the recent tuberculosis epidemic we had in northeastern North Dakota. Likewise, we need the same expertise for tobacco prevention. Again, we NEED to turn to the CDC.

MeritCare Health System

Position Statement on Tobacco Control
January 2001

MeritCare supports the dedication of a minimum investment of 10% of proceeds received from the tobacco settlement for a state-wide initiative to reduce the addiction, disease, disability and death caused by the use of tobacco products. State appropriated funding for a long-range, comprehensive science-based best practice approach to tobacco prevention and treatment can have a notable health and economic impact on people in North Dakota.

High Impact Priorities

1. **Tobacco dependence treatment (cessation) and risk elimination**
   - ① **Systems and programs for identifying and treating tobacco use**
   - ② **Community-based tobacco dependence treatment services**
   - ③ **Protection of nonsmokers from the effects of secondhand smoke**
     - *The youth smoking rate in North Dakota, at about 40%, is one of the highest in the nation*
     - *Over 80% of adults began smoking before the age of 18*
     - *Each year, about 50% of current smokers attempt to quit*
     - *Research indicates cessation rates increase 30% with professional advice to quit*
2. **Public education and awareness**
   - ④ **Education and awareness to diminish tobacco consumption**
     - *The tobacco industry spends about $18.50 per person promoting tobacco products in our state*
     - *Research shows that counter-advertising is effective in reducing tobacco use, especially when combined with school, community and clinic-based programs*
     - *Estimates suggest a tobacco control program to effectively counter tobacco-related marketing will require at least $7 for every North Dakotan*
3. **Community-based, long-term prevention programs**
   - ⑤ **Grants for schools, law enforcement, local coalitions, health providers and others to support best practice approaches to reduce the appeal and use of tobacco**
     - *In 1995, North Dakota tobacco-related health care expenses totaled about $180 million*
     - *An estimated 1,000 North Dakotans lose their lives to tobacco-related illnesses each year*
     - *Tobacco use is the single most preventable cause of death and disease in our country*
4. **Research and evaluation**
   - ⑥ **Tobacco-related studies**
   - ⑦ **A public surveillance and evaluation program to assess impact**
5. **Independent oversight and accountability for a state-wide plan**
   - ⑧ **Accountability and fund administration via an independent non-profit foundation with broad representation from health and human service providers, payers, government, and community members**

> *"The North Dakota tobacco settlement affords the opportunity to invest in a comprehensive best practice approach to preventing and reducing tobacco use that will make a significant impact on improving health and quality of life and decreasing tobacco related health costs."*
>
> *Roger L. Gilbertson, MD, President and CEO*

Contact: Susan Beseth, Public Policy & Government Relations • MeritCare Health System • 720 N. 4th St. • Fargo, ND 58122 • (701)234-6822 (phone) • (701)234-6868 (fax) • susanbeseth@meritcare.com

Revised January 5, 2001

The CDC has established research-based "Best Practices" for reducing the burden of tobacco use in each of the 50 states. To arrive at the $8.2 million figure specifically for North Dakota, the CDC studied the most effective methods and programs across the country, and applied that knowledge to our state's special characteristics (including ND's sparse population and current smoking prevalence rates).

"Best Practices" specify that, *to be effective*, tobacco prevention must be: (1) multi-faceted (comprehensive), (2) fully funded, and (3) sustained over time. Given ND's unique features, an annual investment of $8.2 million IS REQUIRED to implement all the inter- dependent components of prevention simultaneously. This is largely a matter of economies of scale. We know that, compared to more densely populated states, ND needs a higher per capita investment to deliver vital water, power and rail services, and even 911 access. For precisely the same reasons, ND needs a higher per capita investment to provide EFFECTIVE tobacco prevention to everyone !

Implementing a comprehensive tobacco prevention program is akin to administering a vaccine for a deadly contagious disease: Spending enough money to immunize only a portion of the population may produce a visible benefit, but spending enough to immunize <u>everyone</u> will produce a much greater benefit. So, setting the funding level for ND's statewide tobacco prevention program boils down to the question: How many kids do we want to save?

$8.2 million each year sounds like a lot, but let's compare it to what tobacco use costs us now.

- EACH YEAR, tobacco use costs North Dakota 1,000 lives.
- EACH YEAR, tobacco use costs North Dakotans $180 million in hospital and other medical expenses.
- EACH YEAR, North Dakotans pay $70 million in taxes alone (state and federal) to cover tobacco-related health expenses. This means each North Dakota household pays about $290 in taxes per year just for tobacco-related healthcare costs.

If we don't act now to stem the tobacco epidemic, these costs will only go up.

If we try to solve the problem with less money, it will NOT be money well spent. A misguided or piecemeal approach to this critical problem will likely do more harm than good. A piecemeal approach will fail to reduce tobacco-use rates. That will delight critics, who will then hold up this failure as proof that no further money should be invested in tobacco prevention efforts anywhere.

There are many worthy health-related causes that cry for money. I am well aware of this because I serve on our public health board and see the need that our local health unit has for more money -- which is one of the items now included in the Amendment, Section 10. But I, along with our entire health board recognize that we will be saving more lives and saving more money if we put **all this money into tobacco prevention**.

We have to remember that tobacco use is our state's leading cause of preventable death, killing more North Dakotans than --illegal drugs, --homicides,-- suicides, --AIDS, --car accidents, and --alcohol *combined*. That's why all the non-tobacco items need to be removed from Senate Bill 2380 ! **The entire appropriation must be devoted exclusively to tobacco, AND the total amount needs to be increased to meet at least the CDC's minimum recommendation of $8.2 million per year.**

We **DO** have the knowledge and the tools to halt the tobacco epidemic. And, right now, North Dakota's Tobacco Settlement ($25 million per year) gives us an historic opportunity to get the job done. Effective tobacco prevention work is so powerful, that our top health officials say -- using Settlement dollars to fund it constitutes the greatest opportunity to save lives **since the development of the polio vaccine.**

"A CDC-Based Comprehensive Tobacco Prevention Program for North Dakota -- Q. and A."

Q. 1 --What is meant by "CDC-Based" ?

A.: "CDC-Based" means that the program must be firmly based on science. It must include only activities that have been proven effective, as reported by the U.S. Centers for Disease Control (CDC) in the 1999 publication "*Best Practices for Comprehensive Tobacco Control Programs.*"

The CDC findings regarding "what works" are based on published evidence-based practices and/or evidence of the efficacy of large-scale, sustained tobacco-use-reduction efforts in other states.

In other words, North Dakota's program will not fund any activities whose effectiveness has not been established by good science.

*Please refer to attached excerpted pages from the CDC's "Best Practices" manual.

Best Practices for Comprehensive Tobacco Control Programs, August 1999

Excerpts from C.D.C.'s "road map" for N.D. to follow...

The following individuals from the Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, contributed to the preparation of this publication:

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Gabrielle B. Starr, MA, Program Analyst
Brian T. Judd, Graphics Specialist
Heather J. Selin, MA, Health Policy Analyst
Julie A. Fishman, MPH, Health Policy Analyst
Melissa S. Albuquerque, Public Health Educator
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Jeffrey W. McKenna, MS, Chief, Health Communications Branch
Corinne G. Husten, MD, MPH, Chief, Epidemiology Branch
Paulette E. Murphy, MLIS, Technical Information Specialist
Donald J. Sharp, MD, Senior Medical Officer



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Office on Smoking and Health

CDC

North Dakota

[redacted]

[redacted]gust 1999

NOTE: A justification for each program element and the rationale for the budget estimates are provided in Section A.
An upper and a lower estimate are presented for each budget category.
The funding required for implementing programs will vary depending on state characteristics, such as sociodemographic factors, tobacco use prevalence, and other factors. Therefore, the funding ranges presented here are illustrative.

I. Community Programs to Reduce Tobacco Use

Upper Estimate	$2,462,000	Formula: $1,200,000 (statewide training and infrastructure) + $2.00 per capita
Lower Estimate	$1,299,000	Formula: $650,000 (statewide training and infrastructure) + $0.70 per capita

II. Chronic Disease Programs to Reduce the Burden of Tobacco-Related Diseases

Upper Estimate	$4,162,000	Formula: See attached section
Lower Estimate	$2,787,000	Formula: See attached section

III. School Programs

Upper Estimate	$1,498,000	Formula: $750,000 (statewide training and infrastructure) + $6 per student (K-12)
Lower Estimate	$999,000	Formula: $500,000 (statewide training and infrastructure) + $4 per student (K-12)

IV. Enforcement

Upper Estimate	$817,000	Formula: $300,000 (inter-agency coordination) + $0.80 per capita
Lower Estimate	$426,000	Formula: $150,000 (inter-agency coordination) + $0.43 per capita

V. Statewide Programs

Upper Estimate	$641,000	Formula: $1.00 per capita
Lower Estimate	$257,000	Formula: $.40 per capita

[redacted]Counter-Marketing

Upper Estimate	$1,923,000	Formula: $3.00 per capita
Lower Estimate	$641,000	Formula: $1.00 per capita

VII. Cessation Programs

Upper Estimate	$2,865,000	Formula: $1 per adult (screening) + $2 per smoker (brief counseling) + $137.50 per served smoker (50% of program cost for 10% of smokers) + $275 per served smoker (100% of program cost for 10% of publicly financed smokers)
Lower Estimate	$687,000	Formula: $1 per adult (screening) + $2 per smoker (brief counseling)

Subtotal (I to VII above)

Upper Estimate	$14,385,000
Lower Estimate	$7,096,000

VIII. Surveillance and Evaluation

Upper Estimate	$1,439,000	Formula: 10% High Estimates Subtotal
Lower Estimate	$710,000	Formula: 10% Low Estimates Subtotal

IX. Administration and Management

Upper Estimate	$720,000	Formula: 5% High Estimates Subtotal
Lower Estimate	$355,000	Formula: 5% Low Estimates Subtotal

Total Program Annual Cost

Upper Estimate	$18,547,000
Lower Estimate	$8,161,000

[redacted]Capita Funding Ranges

Upper Estimate	$25.82
Lower Estimate	$12.73

Office on Smoking and Health
Centers for Disease Control and Prevention
Telephone Number: 770-488-5705
http://www.cdc.gov/tobacco
E-Mail Address: tobaccoinfo@cdc.gov

Introduction

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

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

The Centers for Disease Control and Prevention (CDC) has prepared these best practices to help States assess options for comprehensive tobacco control programs and to evaluate their local funding priorities. This document draws on "best practices" determined by evidence-based analyses of excise tax-funded programs in California and Massachusetts and by CDC's involvement in providing technical assistance in the planning of comprehensive tobacco control programs in other States with excise tax-funded programs (Oregon and Maine) and in the four States that individually settled lawsuits with tobacco companies (Florida, Minnesota, Mississippi, and Texas).

Reducing tobacco use requires a partnership between the Federal government and States. The Federal government has undertaken a number of important activities that provide a foundation for State action. Scientific data about the extent of tobacco use, the impact of tobacco use, and interventions to reduce tobacco use have been generated and disseminated by several Federal government agencies including the National Institutes of Health, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, and the Agency for Health Care Policy and Research.

The Federal government has supported a number of surveys of tobacco use among adults and youth through the Centers for Disease Control and Prevention (Behavioral Risk Factor Survey, National Health Interview Survey, and Youth Risk Behavior Survey), the National Institutes of Health (Current Population Survey and Monitoring the Future Study), and the Substance Abuse and Mental Health Services Administration (National Household Survey on Drug Abuse). SAMHSA's household survey is of particular note because it will collect annual data on brands of cigarettes and other forms of tobacco used by young people and adults.

The Federal government also has sponsored research on the health impact of tobacco use, determinants of tobacco use, and interventions to reduce tobacco use. The majority of this research has been supported by the National Institutes of Health's National Cancer Institute (NCI); however, other Institutes also have been involved, including the National Institute on Drug Abuse, National Institute of Child Health and Development, and the National Heart, Lung, and Blood Institute. Besides supporting disease-specific research, NCI has supported intervention studies including mass media and school trials and large-scale demonstration projects such as COMMIT and ASSIST. The Centers for Disease Control and Prevention also supports applied research through its Prevention Research Centers; this research has a particular focus on racial/ethnic and gender differences in tobacco use determinants and patterns.

Furthermore, multiple Federal government agencies support programs to prevent and reduce tobacco use. SAMHSA implements the Synar regulation to reduce youth access to tobacco products through State-level compliance activities. FDA is implementing the minors' access provisions of its tobacco regulations through contracts with States for enforcement efforts and educational interventions, including retailer outreach and media campaigns. The Agency for Health Care Policy and Research has published clinical practice guidelines on smoking cessation and has worked with a variety of health care organizations to ensure that the guidelines are implemented. Additionally, CDC supports several programs to prevent and reduce tobacco use including the National Tobacco Control Program, which in FY 1999 will fund all 50 States, the District of Columbia, and the territories to establish core tobacco use prevention and reduction programs. CDC has also developed educational and media programs including the Media Campaign Resource Center, which makes high-quality, anti-smoking advertising materials available for use by States and organizations.

Although the Federal government has undertaken a number of critical activities to curb tobacco use, State and local community action is required to ensure the success of tobacco control interventions. In acknowledgment of the unique role that States and communities play in tobacco control efforts, these best practices provide technical information to assist States in designing comprehensive programs.

Introduction

In this guidance document, CDC recommends that States establish tobacco control programs that are comprehensive, sustainable, and accountable. This document draws upon "best practices" determined by evidence-based analyses of comprehensive State tobacco control programs. Based upon this evidence, specific funding ranges and programmatic recommendations are provided. Local analysis of each State's priorities should shape decisions regarding funding allocations for each recommended program component. The funding required for implementing programs will vary depending on state characteristics, such as demographic factors, tobacco use prevalence, and other factors. Although the type of supporting evidence for each of the recommended nine program components differs, evidence supports the implementation of some level of activity in each program area. In general, States typically have selected a funding level around the middle of the recommended ranges. Current allocations range from $2.50 to over $10; however, no State is currently implementing all of the recommended program components fully. Approximate annual costs to implement all of the recommended program components have been estimated to range from $7 to $20 per capita in smaller States (population under 3 million), $6 to $17 per capita in medium-sized States (population 3 to 7 million), and $5 to $16 per capita in larger States (population over 7 million).

The Health Consequences of Tobacco Use[1]

Tobacco use is the single most preventable cause of death and disease in our society. Annually, tobacco use causes more than 430,000 deaths and costs the Nation approximately $50–$73 billion in medical expenses alone. Tobacco use is addictive: nearly 70% of smokers want to quit smoking, but only 2.5% are able to quit permanently each year. Most smokers start smoking as adolescents. The number of American teenagers taking up daily smoking jumped 73% between 1988 and 1996. Each day, more than 6,000 persons younger than age 18 try their first cigarette, and more than 3,000 become daily smokers. One in three teens who are regular smokers will eventually die of smoking-related causes.

Other tobacco products also have serious health consequences. Use of smokeless tobacco is associated with leukoplakia and oral cancer. Although very little was known until recently about the health risks of cigar smoking, there is now strong evidence of causal relationships between regular cigar use and cancers of the lungs, larynx, oral cavity, and esophagus. These consequences are of particular concern because in 1997, 22% of high school students smoked cigars and 9.3% used smokeless tobacco.

The risks of tobacco use extend beyond actual users. Nearly 9 of 10 nonsmoking Americans are exposed to environmental tobacco smoke (ETS). Exposure to ETS increases nonsmokers' risk for lung cancer and heart disease. Among children, ETS is also associated with serious respiratory problems, including asthma, pneumonia, and bronchitis. Additionally, substantial evidence now links ETS with sudden infant death syndrome and low birth weight.

The consequences of tobacco use have become an issue of global concern. The World Health Organization estimates that 3 million people die every year of tobacco-related diseases. Without effective international tobacco control programs, the death toll will increase to as many as 10 million people by 2030, and 7 million of these deaths will occur in developing countries. Successful programs in the United States to reduce tobacco use will provide valuable models to help other countries successfully address the growing tobacco use epidemic.

Efficacy of Comprehensive Tobacco Control Programs: California and Massachusetts

Evidence supporting the programmatic recommendations in this guidance document are of two types. Recommendations for chronic disease programs to reduce the burden of tobacco-related diseases, school programs, cessation programs, enforcement, and counter-marketing program elements are based primarily upon published evidence-based guidelines. Other program categories rely mainly upon the evidence of the efficacy of the large-scale and sustained efforts of two States (California and Massachusetts) that have been funding comprehensive tobacco prevention and control programs using State tobacco excise taxes. Increasing excise taxes on cigarettes reduces tobacco consumption rates. But more importantly, when the excise taxes support effective community, media, and school programs to prevent tobacco use, decreases in per capita consumption will continue even if industry lowers tobacco prices to preexcise tax values.[2] The tobacco industry itself has concluded that "the California campaign and those like it represent a very real threat to the industry in the intermediate term..."[3] and "the environment for the sale and use of tobacco products in California continues to deteriorate. And because California serves as a bellwether State, tobacco-related steps taken there often find their way into other States."[4]

Best Practices

This document provides evidence to support each of nine specific elements of a comprehensive program. However, in addition to highlighting the importance of the individual program elements, it is equally critical to recognize why these individual components must work together to produce the synergistic effects of a comprehensive program.[3] Reducing the broad cultural acceptability of tobacco use necessitates changing many facets of the social environment. This scale of societal change is a complex process that must be addressed by multiple program elements working together in a comprehensive approach. For example, school programs are effective in isolation, but evidence indicates that their efficacy is greatly increased when combined with community programs and media campaigns.[4] Through evidence-based analyses in California and Massachusetts, in-depth involvement with settlement States, and published evidence of effective tobacco control strategies, CDC recommends that States establish tobacco control programs that contain the following elements:

- Community Programs to Reduce Tobacco Use.
- Chronic Disease Programs to Reduce the Burden of Tobacco-Related Diseases.
- School Programs.
- Enforcement.
- Statewide Programs.
- Counter-Marketing.
- Cessation Programs.
- Surveillance and Evaluation.
- Administration and Management.

For each of these categories, the best practices that follow provide

- Justification for the program element.
- Budget estimates for successful implementation.
- Core resources to assist implementation.
- References to scientific literature.

All core resources listed in this document, or the contacts to obtain them, are available from CDC's Office on Smoking and Health. To request copies, please call 770-488-5705 (press 2 or 3) or send an E-mail to tobaccoinfo@cdc.gov.

General Planning Resources

Advocacy Institute Tobacco Control Project. The Money is Coming! The Money is Going! Strategic Advisory Series Online Publication. 1998. (http://www.scarcnet.org/hsap/intrmon.htm).

American Cancer Society. Advocating for State Tobacco Control: An American Cancer Society Planning Guide. June 1998.

Attorney General's Task Force. A Comprehensive Tobacco Prevention and Control Plan for Washington State. November 1998. (http://www.wa.gov/ago/pubs/Tobacco.PDF).

California Department of Health Services. A Model for Change: The California Experience in Tobacco Control. Sacramento, CA: California Department of Health Services, October 1998.

Centers for Disease Control and Prevention, Office on Smoking and Health. State Tobacco Control Highlights—1996. Atlanta, GA: Centers for Disease Control and Prevention, 1996. (Updated on http://www.cdc.gov/tobacco/statehi/statehi.htm).

Minnesota Health Improvement Partnership. Tobacco Work Group. Tobacco Use Prevention and Reduction in Minnesota: Elements, Roles and Costs of a Comprehensive Plan. December 1998.

Pierce-Lavin C, Geller AC, Hyde J, Evjy J, editors. Robert Wood Johnson Foundation and Boston University School of Medicine Working Group: Creating Statewide Tobacco Control Programs After Passage of a Tobacco Tax. *Cancer* 1998;83(12 Supplement):2659–774.

Texas Inter-Agency Tobacco Task Force. Legislative Plan. October 1998.

U.S. Department of Health and Human Services. Office of Public Health and Science. Healthy People 2010 Objectives. Chapter 3. Tobacco Use. Washington, DC: U.S. Department of Health and Human Services, September 15, 1998. (http://web.health.gov/healthypeople/2010Draft/object.htm).

References

1 U.S. Department of Health and Human Services. Office of Public Health and Science. Healthy people 2010 objectives. Tobacco use. Washington, DC: U.S. Department of Health and Human Services, September 15, 1998;3:1-24 (http://web.health.gov/healthypeople/2010Draft/object.htm).

2 Centers for Disease Control and Prevention. Cigarette smoking before and after an excise tax increase and antismoking campaign—Massachusetts, 1990–1996. *MMWR* 1996;45:966–70. (http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00044337.htm).

3 Verner KL. California antismoking campaign funding (letter), January 29, 1991. RJ Reynolds Litigation Document, Minnesota Depository, Bates No.: 507755351–5354.

4 California Department of Health Services. A model for change: the California experience in tobacco control. Sacramento, CA: California Department of Health Services, October 1998.

5 Controlling the smoking epidemic. Report of the WHO Expert Committee on Smoking Control. Geneva: World Health Organization, 1979. WHO Technical Report Series, No.: 636.

6 U.S. Department of Health and Human Services. Preventing tobacco use among young people: a report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1994.

Q. 2. -- What is meant by "Comprehensive" ?

A.: **"Comprehensive" has TWO important meanings here:**

(1) **In terms of targeted population, North Dakota's tobacco-use-reduction program must have a comprehensive (*all-inclusive*) focus. Current science clearly demonstrates that effective tobacco programs must focus on adults and youth simultaneously. Programs that focus on only kids have been known to fail (as did the Hutchinson, WA, school-based program), and even to "backfire."**

***Please refer to attached "Antismoking Efforts Should Focus on Adults As Well As Kids."**

(2) **In terms of program content, North Dakota's initiative must include 7 individual components working together *at the same time*. This is because reducing tobacco use (especially among youth) means reducing the broad cultural acceptability of tobacco use—and THAT necessitates changing many facets of the social environment. Such "social norming" is a complex**

process that must be addressed by multiple program elements working together toward the same goal in a comprehensive approach. It was the tobacco industry's skillful manipulation of the social environment that created the tobacco epidemic in the first place, and we know that changing that social environment is the only way we can reverse the damage. Thus, to be effective, North Dakota's initiative must be comprehensive in content, including the best, science-based:

- 1. Community Programs to Reduce Tobacco Use
- 2. Chronic Tobacco-Related Disease Program
- 3. School Programs
- 4. Enforcement
- 5. Statewide Program
- 6. Counter-Marketing & Public Education
- 7. Tobacco-Dependence Treatment Programs

*Please refer to attached: --Excerpted pages from the CDC's "Best Practices" manual
--"WA Report only underscores need for COMPREHEHSIVE program"
(printed on reverse of blue-colored"We Can Cut Smoking Rates")

Antismoking Efforts Should Focus on Adults As Well As Kids

by AliciaMarie Belchak Source: Reuters, Thursday, 8/3/00

NEW YORK (Reuters Health) - Antismoking policies targeting youths won't significantly reduce the number of smokers in the US for decades, according to researchers at the Pacific Institute for Research and Evaluation. Campaign efforts should be directed towards adults instead, they suggest.

Recent policies to reduce tobacco use have focused primarily on youths, justified by the high rate of smoking initiation before age 18. Laws have limited cigarette sales to minors while school-based education programs and antismoking advertising have targeted adolescents.

But the new study findings, published in the August issue of the American Journal of Public Health, journal of the American Public Health Association, suggest that these antismoking campaigns may have a more limited effect on reducing the national smoking population than experts previously thought.

The investigators, led by Dr. David T. Levy, developed a model to evaluate the overall effect youth-related polices might have on current and future smoking rates. Using birth, death, and smoking rates from 1993 as a baseline, the researchers used computer spreadsheets to predict the various outcomes of antismoking efforts through the year 2043.

In the first scenario, the researchers assumed no change in the smoking rate over the 50-year period. The second scenario considered what might happen with a 50% reduction in smoking. Two more scenarios looked at a 100% reduction and a 100% reduction with the assumption that some (about 25%) would start smoking after age 18.

Investigators found that even under optimal assumptions, the smoking rate took decades to fall. In the first scenario assuming status quo could be maintained, the model predicted smoking rates might be 15% of the total population or 41 million people by 2043, a decrease from the 19% (48 million people) in 1993.

With a 50% reduction, the smoking rate would drop to 14% in 20 years and just under 11% (30 million) in 50 years. Even if a 100% reduction in smoking rates could be achieved, the model projected that the "rate of smoking would not be halved until about 2028, 35 years into the future," Levy and colleagues note. After 50 years, the number of smokers would have fallen about 13%, still leaving over 15 million smokers.

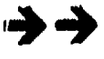
"Efforts to reduce tobacco use among adults are likely to have a more immediate payoff...than a policy that is focused largely on youth prevention," Levy's team concludes.

That does not necessarily mean giving up current policies, however, according to Rae Jean Proescholdbell, an antismoking policy researcher at Arizona State University.

"What (this study) is saying is that if we ignore adults, it will take a very long time to see results and in the meantime, we're spending lots of money on smoking-related health problems," she said. "I see this as an argument or good reason to target both adolescent and adults. Smoking is so complicated and addictive that we really need to use all the methods we can to reduce or prevent smoking."

SOURCE: American Journal of Public Health 2000;90:1311-1314.

Message Author: glantz@medicine.ucsf.edu



Dec. 21, 2000 --

From Stan Glantz, (Ph.D., Professor of Medicine, Member of the Caradiovascular Research Institute, Member of the Institute for Health Policy Studies, University of California, San Francisco):

While the paper published this week in the Jounral of the National Cancer Institute that concluded that an intensive school program failed to affect smoking behavior has upset many people, I found the results predictable.

Several surveys have shown that young children (and the intervention they studied began in the third grade) are *very* anti-tobacco. As a result, there is little room for a program effect.

The tobacco industry markets smoking to kids as a way to be grown up. Educational programs concentrating on kids simply reinforce this message.

The tobacco industry has understood the fact that school programs are not effective. That is why it does not fight them ... and in fact in some cases has encouraged funding of them.

The best way to reach kids is to integrate them into a larger program directed at the adult community, particularly young adults. That is how the tobacco industry does it.

Q. 3 -- Why will this program cost N. D. $8.2 million/year ?

A: The CDC has determined $8.2 million per year is the minimum amount North Dakota must invest in order to achieve a true comprehensive program -- AND -- in order to realize a substantial drop in tobacco use (as seen in other states WITH well-funded programs).

The CDC has established research-based "Best Practices" for reducing the burden of tobacco use in each of the 50 states. To arrive at the $8.2 million figure specifically for North Dakota, the CDC studied the most effective methods and programs across the country, and applied that knowledge to our state's unique sociodemographic and geographic features (including ND's sparse population and current smoking prevalence rates).

"Best Practices" specify that, *to be effective*, tobacco prevention must be: multi-faceted (comprehensive), fully funded, and sustained over time. Given ND's unique features, an annual investment of $8.2 million IS REQUIRED to implement all the inter-dependent components of prevention simultaneously. (NOTE: This is largely a matter of economies of scale. Compared to more densely populated states, ND needs a higher per capita investment to deliver vital water, power and rail services, and even 911 access. For precisely the same reasons, ND needs a higher per capita investment to provide EFFECTIVE tobacco prevention to everyone !)

Implementing a comprehensive tobacco prevention program is akin to administering a vaccine for a deadly contagious disease: Spending enough money to immunize only a portion of the population will produce a visible benefit, but spending enough to immunize everyone will produce a much greater benefit. Thus, setting the funding level for ND's statewide tobacco prevention program boils down to the question: How many kids do we want to save?

((And Remember: Meanwhile, the tobacco industry is spending $12 million per year to PROMOTE tobacco use in North Dakota !!))

***Please refer to attached: --CDC's "Best Practices," – Two Feb. 12, 2001, emails from CDC, & -- "We Can Cut the Smoking Rates"**



"May, Dianne"
<zfg2@cdc.gov>
02/12/01 01:56 PM

To: "vrosenau@co.barnes.nd.us" <vrosenau@co.barnes.nd.us>

cc: "Park, Barbara" <bzp0@cdc.gov>, "Lancaster, Brick" <bxl0@cdc.gov>, "Pechacek, Terry F." <txp2@cdc.gov>, "May, Dianne" <zfg2@cdc.gov>, "jeanne prom (E-mail)" <jprom@state.nd.us>

Subject: ND funding recommendations in Best Practices

Hi Vicki,

Here's a quick response to your question about how CDC determined the funding levels for North Dakota as published in Best Practices. I'll check with Terry to get a more in-depth response for you.

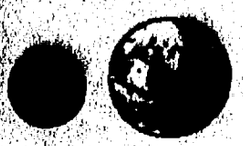
In the Executive Summary of Best Practices, there is a description of the methodology used to determine the state-specific funding levels. Part of that description reads, "The funding required for implementing programs will vary depending on state characteristics, such as demographic factors, tobacco use prevalence, and other factors."
In North Dakota, some of the following were taken into consideration when the funding levels were calculated.

* Demographics: Your state is primarily a rural state with a small population either concentrated in a couple of urban areas or scattered across a large area. The distribution of population presents some issues in terms of effectively reaching at-risk populations with tobacco reduction programs.
* Prevalence: The adult smoking prevalence rate is about the same as it is nationwide. But the Native American population has a very high smoking prevalence rate. The smoking rate among youth is higher than the national average. I didn't look up the spit tobacco prevalence rate for North Dakota, but my guess is that it's higher than the national average.
* In addition, the funding levels in Best Practices are not based on the settlement amounts from the Master Settlement Agreement, but rather are based on individual state needs.

Hope this helps.

Dianne

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"Pechacek, Terry F." <txp2@cdc.gov>

02/12/01 02:05 PM

To: "May, Dianne" <zfg2@cdc.gov>, "vrosenau@co.barnes.nd.us" <vrosenau@co.barnes.nd.us>

cc: "Park, Barbara" <bzp0@cdc.gov>, "Lancaster, Brick" <bxl0@cdc.gov>, "'jeanne prom (E-mail)" <jprom@state.nd.us>

Subject: RE: ND funding recommendations in Best Practices

Thanks Dianne. Additional information about why the recommended per capita amount is higher in ND than in some other states, such as California.

First, the costs of setting up staffing and technical assistance for community programs, school programs, and enforcement vary from smaller to larger states, but there are economies of scale for larger states which make the per capita cost lower. In smaller and more rural states, the populations are less dense and more difficult to reach. These factors were taken into consideration in the funding formulae used in Best Practices.

Second, other less populated states such as Vermont and Maine have carefully considered the Best Practices recommendations and developed comprehensive local tobacco control plans. These states have found that they do need to invest at a higher per capita level than larger states in order to implement the recommended science-based intervention programs.

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We Can Cut the Smoking Rates

By U.S. Surgeon General David Satcher

U.S. Surgeon General David Satcher in *The Washington Post*, May 25, 1999:

"The single most promising public health intervention today is not the development of a new drug but the opportunity to invest part of the recent $246 billion settlement...into ...proven programs that would prevent our nation's children from smoking. ... There can be *no greater priority to public health, community health or family health in this country than ensuring a robust and comprehensive tobacco control program in every state.*"

From comments by U.S. Surgeon General David Satcher in *The Washington Post*, Wednesday, September 6, 2000:

During the past four decades, we have made unprecedented gains in preventing and controlling tobacco use. Since 1964, when Luther Terry issued the first surgeon general's report on smoking and health, the smoking rate among adult Americans has dropped from 43 % to under 25 %.

Even so, the sobering reality is that smoking remains the leading cause of preventable death and disease in our nation, and that those who suffer the most are poor Americans, minority populations and young people.

Although our knowledge remains imperfect, we know more than enough to address the tobacco control challenges of the 21st century. In fact, smoking rates among teens and adults in the United States could be cut in half by the end of this decade if the nation would fully implement antismoking programs using effective approaches that are already available.

This was the finding of "Reducing Tobacco Use," the latest surgeon general's report on smoking--the 52nd surgeon general's report ever released and the 29th report that dealt with tobacco-related issues. While previous reports have dealt mostly with identification of smoking-related problems, this one dealt with identifying solutions. It provides an in-depth analysis of the effectiveness of various methods to reduce tobacco use: educational, clinical, regulatory, economic and comprehensive.

The report calls for the widespread use of approaches and methods, especially in combination, that have proven to be effective in substantially reducing the number of people who will become addicted to nicotine; increasing the success rate of young people and adults trying to quit tobacco use; decreasing nonsmokers' exposure to tobacco smoke; reducing disparities related to tobacco use and its health effects among different population groups: and decreasing the future health burden of tobacco-related disease and death.

...The report concludes that the **use of the tobacco settlement funds by states to implement comprehensive approaches**--combining community interventions, mass media campaigns and program policy and regulation--**is most effective in changing social norms and reducing tobacco use.**

We must respond aggressively to the serious challenges we still face: most important, the tobacco industry's continuing campaign to advertise and promote tobacco products. The industry spent $6.7 billion in 1998 to market cigarettes. We need fair but aggressive measures to regulate these marketing activities. Our report shows that we have the tools, the knowledge and the resources to cut smoking rates in half by the end of the decade.

The question is: Do we have the will?

WA Report only underscores need for COMPREHENSIVE program

January 2, 2001 -- From U.S. Centers for Disease Control:

On Wednesday, December 20, 2000, researchers at the Fred Hutchinson Cancer Research Center in Seattle published a new report in the *Journal of the National Cancer Institute* that provided results of a 15-year randomized trial conducted in 40 Washington state school districts to determine the long-term impact of classroom curriculum on youth smoking. The study examined anti-smoking curriculum units taught to students in grades 3 through 10, and found that a curriculum based approach to prevent youth smoking was ineffective when used alone in a school setting.

The Centers for Disease Control and Prevention (CDC) applauds the quality of the National Cancer Institute's research trial, the Hutchinson Smoking Prevention Project, and what this study has to teach us about a social influences curriculum when used alone. While the findings of this study raise questions about one type of curriculum, the public health practice implications are consistent with the CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction* and the CDC's *Best Practices for Comprehensive Tobacco Control Programs*. The CDC recommends that school-based programs, in order to be effective, need to involve much more than classroom curriculum alone. Curricula need to be implemented within the broader context of strictly enforced school tobacco-free policies, active parent and community involvement, and cessation services for students and staff, and they need to be coordinated with community and media efforts to reduce tobacco use. Additionally, CDC recommends that the curriculum components of a comprehensive program effort be based upon programs that have demonstrated long-term efficacy in research trials.

While more research is needed, the 2000 Surgeon General's Report, *Reducing Tobacco Use* concluded that we know more than enough to act now. The report concludes that educational strategies conducted in conjunction with community- and media-based activities can postpone or prevent smoking onset in 20 to 40 percent of adolescents. Unfortunately, fewer than 5 percent of schools nationwide are implementing the major components of the tobacco use prevention guidelines recommended by the CDC. More research is needed that fully explores the comprehensive approach to working through schools to change health behaviors among youth. This research should emphasize combining the effective curricula interventions in conjunction with school policy changes as well as community and media programs, as recommended in the CDC's *Best Practices* and the 2000 Surgeon General's Report.

The research reviewed within the 2000 Surgeon General's Report found that if the nation would fully implement comprehensive anti-smoking control approaches proven to be effective, it could cut smoking rates among teens in half within the decade, thereby meeting the Healthy People 2010 objectives related to youth tobacco use. **The Hutchinson report simply underscores the critical need for school officials, school staff, students, parents, and community leaders to work together in a comprehensive program effort because they all have a critical role in reducing tobacco use.**

For additional information or advice on tobacco use prevention program that work, please contact Linda Crossett, Division of Adolescent and School Health, 770-488-3258 or Llelwyn Grant, Office on Smoking and Health, (770) 488-5493.

(Signed) Lloyd J. Kolbe
Division of Adolescent and School Health

Elizabeth Majestic
Office on Smoking and Health

Q. 4 – How much does tobacco use cost North Dakota ?

A.: The costs of tobacco use in North Dakota are ENORMOUS:

(1) EACH YEAR, tobacco use costs North Dakota 1,000 lives.

(2) EACH YEAR, tobacco use costs North Dakotans $180 million in hospital and other medical expenses.

(3) EACH YEAR, North Dakotans pay $70 million in taxes alone (state and federal) to cover tobacco-related health expenses. This means each North Dakota household pays about $290 in taxes just for tobacco-related healthcare costs.

***Please refer to attached "The Toll of Tobacco in North Dakota"**

Special Reports

State Tobacco Settlement

The Toll of Tobacco in North Dakota

State Settlement Overview for North Dakota

Tobacco Use in North Dakota

High school students who smoke	45%
High school males who use smokeless tobacco	N/A
Number of kids (under 18) who become new daily smokers each year	2000
Kids exposed to secondhand smoke at home	42,000
Number of packs of cigarettes illegally sold to kids in North Dakota each year	0.7 million
Adults in North Dakota who smoke	22%

While adult smoking has generally been decreasing throughout the country in recent years, these declines have slowed or stopped. In contrast, smoking among kids increased steadily throughout much of the 1990s. Although national underage smoking rates finally dropped slightly from 1997 to 1998, they remain at historically high levels. Over the past ten years, the number of kids under 18 in the U.S. who become new daily smokers each year has risen by more than 70 percent.

Deaths in North Dakota From Smoking

Number of people who die each year in North Dakota from smoking	900
Number of North Dakota kids now under 18 who will die from smoking (if current trends continue)	12,000

Smoking kills more people than alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined -- and thousands more die from other tobacco-related causes -- such as fires caused by smoking (more than 1,000 deaths/year nationwide), exposure to second hand smoke (more than 40,000 deaths), and smokeless tobacco use. No good estimates are currently available, however, for the number of North Dakota citizens who die from these other tobacco-related causes, or for the much larger numbers who suffer from tobacco-related health problems each year without actually dying.

Tobacco-Related Monetary Costs

Annual health care expenditures in North Dakota directly related to tobacco use	**$180 million**
Residents' state and federal tax burden caused by tobacco-related health costs	**$70 million**
North Dakota government Medicaid payments directly related to tobacco use	**$10 million**
Additional annual expenditures in North Dakota 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 second hand smoke, smoking-caused fires, and smokeless tobacco use. Although these additional health expenditures certainly total in the tens of millions of dollars in North Dakota, and increase the North Dakota government'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+ 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 (about $4+ billion per year nationwide for commercial establishments alone). No good state-specific estimates of these non-health costs from tobacco are available, but North Dakota's pro-rata share, based on its population, is at least $90 million per year.

Tobacco Industry Influence

Annual tobacco industry advertising & marketing expenditures nationwide	**$5.2 billion**
Estimated portion spent for North Dakota advertising each year	**$12 million**

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

Sources of Information

Sources of Information for Tobacco's Toll on North Dakota

For state-specific data on deaths caused by smoking, smoking and smokeless tobacco use rates, and other tobacco-related information, see Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, State Tobacco Control Highlights 1997 (1998) or see CDC's state-specific website pages. See also, CDC, "State-Specific Prevalence Among Adults of Current Cigarette Smoking and Smokeless Tobacco Use and Per Capital Tax-Paid Sales of Cigarettes - United States, 1997," Morbidity and Mortality Weekly Report (MMWR) 47(43): 922-926 (November 6, 1998); CDC, Surveillance Summaries, "Youth Risk Behavior Surveillance - United States, 1997," 47(SS-3): 10-12,15-17, 50-54 (August 14, 1998); CDC, "State-Specific Prevalence of Cigarette Smoking Among Adults, and Children's and Adolescents' Exposure to Environmental Tobacco Smoke - United States, 1996," MMWR 46(44): 1038-1043 (November 7, 1997); CDC, "Smoking Attributable Mortality and Years of Potential Life Lost - United States, 1984" [with editor's update for 1990-1994], MMWR 46(20): 444-451 (May 23, 1997); J. R. Hall, Jr., National Fire Protection Association, The U.S. Smoking-Material Fire Problem Through 1996 (September 1997). For projected smoking deaths among today's youth, see CDC, "Projected Smoking-Related Deaths Among Youth -- United States," MMWR 45(44): 971-974 (November 8, 1996). New underage daily smoker estimate based on data from CDC, "Projected Smoking-Related Deaths" (see above) and CDC, "Incidence of Initiation of Cigarette Smoking - United States, 1965-1996)," MMWR 47(39): 837-40 (October 9, 1998).

For data on kids exposed to second hand smoke, see CDC, "State-Specific Prevalence of Cigarette Smoking Among Adults, and Children's and Adolescents' Exposure to Environmental Tobacco Smoke - United States, 1996," MMWR 46(44): 1038-1043 (November 7, 1997). State-specific data is not currently available regarding adult exposure to second hand smoke at their homes, or to the numbers exposed to ETS at workplaces, daycare centers, restaurants, or other public facilities.

For data on number of packs of cigarettes illegally sold to kids, see Cummings, et al., "The Illegal Sale of Cigarettes to US Minors: Estimates by State," American Journal of Public Health 84(2): 300-302 (February 1994). See also, CDC, "Tobacco Use and Usual Source of Cigarettes Among High School Students - United States, 1995," MMWR 45(20): 413-418 (May 24, 1996).

For nationwide data on smoking trends see CDC, "Tobacco Use Among High School Students - United States, 1997," MMWR 447(12): 229-233 (April 3, 1998); Institute for Social Research, University of Michigan, Monitoring the Future Study; CDC, "Incidence of Initiation of Cigarette Smoking - United States, 1965-1996," MMWR 47(39): 837-40 (October 9, 1998).

For state-specific data on smoking-related health expenditures and smoking-related Medicaid expenditures, see L. Miller, et al., "State Estimates of Total Medical Expenditures Attributable to Cigarette Smoking, 1993," Public Health Reports 113: 447-58 (September/October 1998). See also, L. Miller, et al., "State Estimates of Medicaid Expenditures Attributable to Cigarette Smoking, Fiscal Year 1993," Public Health Reports 113: 140-151 (March/April 1998).

For data on costs associated with smoking or exposure to second hand smoke during pregnancy, see E.K. Adams and C.L. Melvin, "Costs of Maternal Conditions Attributable to Smoking During Pregnancy," American Journal of Preventive Medicine 15(3): 212-19 (October 1998); CDC, "Medical Care Expenditures Attributable to Cigarette Smoking During Pregnancy," MMWR 46(44) (November 7, 1997); U.S. Department of the Treasury, The Economic Costs of Smoking in the U.S. and the Benefits of Comprehensive Tobacco Legislation (March 1998); J.J. Stoddard and B. Gray, "Maternal Smoking and Medical Expenditures for Childhood Respiratory Illness," American Journal of Public Health 87(2): 205-209 (February 1997); E. Dejin-Karlsson, et al., "Does Passive Smoking in Early Pregnancy Increase the Risk of Small-for-Gestational-Age Infants?" American Journal of Public Health 88(10): 1523-1527 (October 1998). State expenditures based on its pro rata share of the national estimates, with the pro rata calculations based on the state's portion of the nationwide population of kids exposed to second hand smoke.

For additional information on tobacco-related costs, see U.S. Department of the Treasury, The Economic Costs of Smoking in the U.S. and the Benefits of Comprehensive Tobacco Legislation (1998); F.J. Chaloupka and K.E. Warner, "The Economics of Smoking," in J. Newhouse and A. Culyer (eds), The Handbook of Health Economics (in press); CDC, MMWR 46(44) (November 7, 1997); CDC, Making Your Workplace Smokefree: A Decision Maker's Guide (1998); D. Mudarri, The Costs and Benefits of Smoking Restrictions: An Assessment of the Smoke-Free Environment Act of 1993 (H.R. 3434), U.S. Environmental Protection Agency report submitted to the Subcommittee on Health and the Environment, Committee on Energy and Commerce, U.S. House of Representatives (April 1994); P. Brigham and A. McGuire, "Progress Toward a Fire-Safe Cigarette," Journal of Public Health Policy 16(4): 433-439 (1995); J.R. Hall, Jr., National Fire Protection Association, The U.S. Smoking-Material Fire Problem Through 1995 (September 1997).

For data on tobacco industry advertising, see Federal Trade Commission (FTC), Report to Congress for 1996 Pursuant to the Federal Cigarette Labeling and Advertising Act (1998) [data for top five manufacturers' cigarette marketing only]; FTC, 1997 Smokeless Tobacco Report (1997) [1995 data from top five smokeless tobacco product manufacturers]. The state total is a prorated estimate based on its population compared to that of the entire country. Actual figures for 1998 are likely to be larger.

Q. 5 – How do we know this program will work?

A.: There is an abundance of proof that *comprehensive programs work* to reduce tobacco use, as long as the programs are well-funded, ongoing, and truly science-based.

- **California, Massachusetts, Oregon, Florida, and other states have adopted comprehensive programs that have successfully and substantially reduced tobacco use (& saved both lives and health-care dollars).**

- **Last year the Institute of Medicine and the National Research Council completed a study of the "question of whether state tobacco control programs can reduce smoking and save lives." They concluded that: "As states contemplate increasing their tobacco control efforts, many have asked if such programs can make a difference. The evidence is clear: They can."**

- **This fact is so well known that a veritable constellation of the most respected and reliable health agencies and experts (both in N.D. and nationwide) have gone on record supporting implementation of comprehensive programs.**

***Please refer to attached:**

- **The IOM's "State Programs Can Reduce Tobacco Use" (excerpted pages and full report)**
- **"Comprehensive Statewide Tobacco Prevention Programs Effectively Reduce Tobacco Use"**
- **"Saving Lives: Tobacco Prevention Works" (brochure)**

State Programs Can Reduce Tobacco Use

National Cancer Policy Board

INSTITUTE OF MEDICINE
NATIONAL RESEARCH COUNCIL

Growing attention is focused on how states can prevent deaths due to tobacco use. Thus state governors, state legislators, and their staffs currently must decide whether to fund tobacco control programs, and, if they do, how much to spend on them.

The National Cancer Policy Board (a joint program of the Institute of Medicine and the National Research Council) is charged with carrying out policy analyses to help the nation deal with cancer; in 1997, it quickly identified tobacco's role as the foremost cause of cancer deaths as its first topic of concern.[1] The board followed debates taking place in state capitals throughout 1998 and 1999, and decided in July 1999, in consultation with the Board on Health Promotion and Disease Prevention of the Institute of Medicine, that it would be useful to summarize evidence about the effectiveness of state tobacco control programs and to briefly describe those programs for state government officials.

Tobacco control will likely remain on the agenda of many states for several years. Public health advocates, tobacco firms, tobacco growers, retailers, and the general public have all been drawn into the debate. This report does not address the merit of tobacco control compared to alternative uses of state funds or attempt to balance the interests of contending stakeholders; instead, it focuses on the narrower question of whether state tobacco control programs can reduce smoking and save lives. As states contemplate increasing their tobacco control efforts, many have asked if such programs can make a difference. **The evidence is clear: They can.**

The stakes are high. Tobacco use kills more Americans each year than any other cause. The estimated 430,000 deaths attributed to tobacco use annually are far more than those caused by illegal drugs, homicides, suicides, AIDS, motor vehicle accidents, and alcohol combined.[2] Lung cancer kills more Americans than breast and prostate cancer combined,[3] and tobacco accounts for over 30% of all cancer deaths and a comparable fraction of deaths due to heart and lung diseases. Yet despite these risks, many, many people start smoking each year. In 1996, over 1.8 million people became daily smokers, two-thirds of them (1.2 million) under age 18.[4]

Over the past decade, states have moved to the forefront of tobacco control. Starting with California in 1988, and followed by Massachusetts, Arizona, Oregon, and other states, referenda have increased tobacco excise taxes and dedicated a fraction of the revenues to reducing tobacco use. Legislatures in other states—such as Alaska, Hawaii, Maryland, Michigan, New Jersey, New York, and Washington—have increased tobacco taxes substantially, raising questions about how much of the revenue should go to tobacco control. In addition, settlements of lawsuits against tobacco firms to recoup state monies spent through Medicaid have now resulted in individual state revenue streams (in Florida, Minnesota, Mississippi, and Texas) or in revenues anticipated through the Master Settlement Agreement with the other states and territories signed in 1998. In aggregate, these agreements could transfer as much as $246 billion from tobacco firms to states over the next 25 years.

What Is the Evidence that State Programs Make a Difference?

The best evidence for the effectiveness of state tobacco control programs comes

Resources on State Tobacco Control Programs

- The Centers for Disease Control and Prevention (CDC) recently surveyed state tobacco control programs and recommended benchmarks.[5] Several other CDC reports are also of interest.[6]
- The National Governors Association (www.nga.org) and the National Conference of State Legislatures (www.ncsl.org) both have projects to monitor state tobacco control developments.
- The National Association of State and Territorial Health Officials (www.astho.org/prevention/tobacco.html) and the National Association of County and City Health Officials (www.naccho.org/PROJECT44.htm) also have tobacco control projects.
- The University of California at San Francisco has analyzed developments in many states (www.library.ucsf.edu/tobacco), and researchers there have worked with California senate staff to prepare model legislation on state tobacco control.[7]
- In addition, several states have evaluated existing programs or have formulated plans for future ones.[8]

- Prospect Associates produced a planning guide on state tobacco control for the American Cancer Society.[9]
- The Robert Wood Johnson Foundation funds the SmokeLess States initiative administered by the American Medical Association (www.ama-assn.org/special/aos/tobacco/main.htm),
- The National Center for Tobacco-Free Kids monitors developments at the state level (www.tobaccofreekids.org), and
- The American Legacy Foundation will also be carrying out national tobacco control activities (www.americanlegacy.org).

from comparing states with different intensities of tobacco control, as measured by funding levels and "aggressiveness." For example, when California and Massachusetts mounted programs that were more "intense" than those of other states, they showed greater decreases in tobacco use compared to states that were part of the American Stop Smoking Intervention Study (ASSIST) funded by the National Cancer Institute.[10] From 1989 to 1993, when the Massachusetts program began, California had the largest and most aggressive tobacco control program in the nation, and it showed a singular decline in cigarette consumption that was over 50% faster than the national average.[11] A recent evaluation of the Massachusetts tobacco control program showed a 15% decline in adult smoking—compared to very little change nationally—thus reducing the number of smokers there by 153,000 between 1993 and 1999.[12] States that were part of the ASSIST program, in turn, devoted more resources to tobacco control than did other states except Massachusetts and California, and they showed in aggregate a 7% reduction in tobacco consumption per capita from 1993 to 1996 compared to .on-ASSIST states.[13] Such a "dose-response" effect is strong evidence that state programs have an impact; that more tobacco control correlates with less tobacco use, and that the reduction coincides with the intensification of tobacco control efforts.

A second line of evidence comes from observing effects on tobacco consumption beyond those associated with price. When tobacco prices rise, sales should drop, and when prices drop, sales should rise. Yet price alone does not explain the observed consumption patterns. In the first 2 years after Oregon's ballot initiative was implemented, for example, cigarette consumption dropped by over 11%, which is 5% more than would be expected from the price increase alone.[14] The recently reported decreases in tobacco use in Alaska, California, and Florida similarly exceed what would be expected from price increases alone. Moreover, when cigarette prices dropped nationwide during 1992–1994, consumption rose in states with small tobacco control efforts but did not rise in 11 of 14 ASSIST states;[15] consumption also plateaued in California and Massachusetts. This suggests that tobacco control measures limited the increase in tobacco sales expected as a result of a price drop.

In the review of tobacco control program elements that follows, results are reported in ranges, and sometimes those ranges are large. It is generally quite difficult to attribute a reduction in tobacco use to any single factor; often, many factors work in parallel. The underlying message is quite clear, however: **Multifaceted state tobacco control programs are effective in reducing tobacco use.**

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
1275 K Street, N.W., Suite 800, Washington, D.C. 20005-4006
(202) 371-9090 FAX (202) 371-9797

To: State Health Officials
State Tobacco Control Program Managers

From: George E. Hardy, Jr., MD, MPH, Executive Director

Re: Institute of Medicine (IOM) Report on Effectiveness of State-based Tobacco Prevention and Control Programs

Date: March 27, 2000

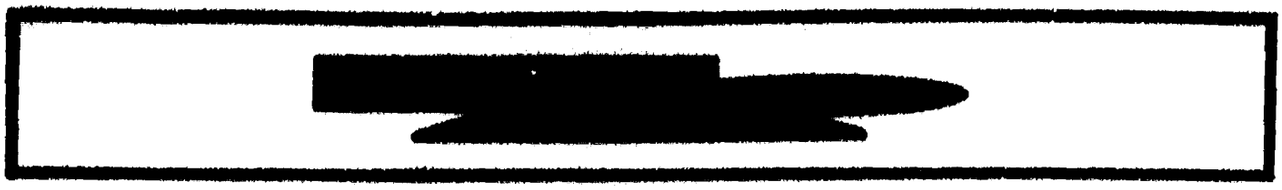
ASTHO is pleased to send you a copy of a recent study conducted by the National Cancer Policy Board to determine if state health agency tobacco control programs can reduce smoking and save lives. The Policy Board concludes that the evidence is clear: comprehensive state programs are effective.

The Policy Board, a joint program of IOM and the National Research Council, consulted with the IOM Board on Health Promotion and Disease Prevention to develop this summary report. Kathleen Toomey, MD, MPH, Director of the Georgia Division of Public Health, is a member of the Health Promotion and Disease Prevention Board.

The study examines data from states that allocated significant funding to tobacco control, primarily from excise taxes, that show impressive reductions in tobacco consumption, as well as a decline in adult smoking and prevention of youth initiation. While the report does not specify that tobacco settlement dollars should be used to fund these prevention programs, it is clear that an investment of major dollars in a sustained, comprehensive strategy does have a positive outcome.

This short report provides brief descriptions of the six suggested elements of an effective program. You will find that information summarized on pages 9 and 10 of the report. Should you wish to have additional copies to share with policy makers in your state, please send an e-mail request to ejohnson@nas.edu or you may download the report form the web at www.nap.edu.





COMPREHENSIVE STATEWIDE TOBACCO PREVENTION PROGRAMS EFFECTIVELY REDUCE TOBACCO USE

There is considerable evidence that public education efforts, community and school-based programs, helping smokers quit, and strictly enforcing laws that establish smoke-free areas and restrict youth access to tobacco products can each significantly reduce tobacco use. Research and experience also shows that these individual elements are most effective when they are all integrated into a comprehensive program. California, Massachusetts, Florida, and Oregon have already followed this comprehensive approach with considerable success, and other states are following their lead.

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

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

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

3) The programs' funding must be sustained over time both to protect initial tobacco use reductions and to achieve further cuts.

Program Success – California

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

- Since the passage of Proposition 99, cigarette consumption in California has declined by 38 percent, or twice as much as the decline of only 16 percent in the rest of the country.[1]

- 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.[2]

- Even after the tobacco industry was successful in dramatically reducing the funding for tobacco use prevention efforts in California, cigarette consumption still declined more in California than in the rest of the country.[3]

- While teenage smoking increased significantly throughout the country from 1990 to 1993, smoking among California teenagers remained constant.[4]

- Since 1993, smoking among 8th graders in California has varied from 12 to 14 percent while increasing from 17 to 22 percent in the rest of the country.[5]

- Since 1992, smoking among 10th graders in California has remained relatively constant at 18 to 19 percent while increasing from 22 to 32 percent in the rest of the country.[6]

- More than 1.3 million Californians have quit smoking because of the California Program.[7]

- A study published in the *American Journal of Public Health* found that the California anti-tobacco media campaign reduced sales of cigarettes by 232 million packs between the third quarter of 1990 and the fourth quarter of 1992. This reduction was independent of the decreases in consumption brought about by the tax increase.[8]

- An analysis of national data on youth smoking showed that, between 1992 and 1994, the national increase in youth smoking rates was slowed significantly in California as a result of the combined effect of a tax increase and a strong tobacco control program.[9]

- The proportion of California tobacco retailers who failed compliance checks for selling tobacco products to minors decreased from 52 percent in 1994 to 21.7 percent in 1997.[10]

- The proportion of California's indoor workers exposed to secondhand smoke at work was cut in half, falling from 29 percent in 1990 to less than 12 percent in 1996.[11]

- The proportion of California children and adolescents exposed to secondhand smoke in the home decreased from 29 percent in 1992 to 13 percent in 1996.[12]

Program Success -- 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. As in California, despite some reductions in funding encouraged by the tobacco industry, the program has achieved considerable success. Data from 1999 demonstrate success in reducing tobacco use among both children and adults.

- Between 1995 and 1999, current smoking among Massachusetts high school students was reduced by 15 percent (from 34.4% to 30.3%).[13]

- Since 1993, the use of spit (smokeless) tobacco by high school males has declined by over 50 percent (from 17.0% to 8.1%).[14]

- The proportion of state tobacco retailers found making illegal sales to youth during compliance checks has fallen from 48 to less than 10 percent since the inception of the program.[15]

- Overall cigarette consumption in Massachusetts has declined by 30 percent since 1992, compared to a decrease of just 8 percent in the rest of the country (excluding California).[16]

- Adult smoking prevalence in Massachusetts has declined from 22.6 to 19.1 percent since the program began, resulting in 150,000 fewer smokers in the state.[17]

- Those who do smoke in Massachusetts are smoking less. The proportion of smokers who smoke 15 or more cigarettes per day declined from 69 percent in 1993 to 59 percent in 1999.[18]

- The proportion of Massachusetts smokers who were advised to quit by their doctor increased from 46 percent in 1993 to 60 percent in 1998.[19]

- Among Massachusetts smokers who try to quit, the success rate has increased from 17.1 percent in 1993 to 24 percent in 1999.[20]

- Between 1990 and 1996, smoking among pregnant women in Massachusetts declined by almost 50 percent (from 25% to 13%).[21]

- An analysis of national data on youth smoking showed that, between 1992 and 1994, the national increase in youth smoking rates was slowed significantly in Massachusetts as a result of the combined effect of a tax increase and a strong tobacco control program.[22]

Early Success in Florida

With funding from its 1997 settlement with the tobacco industry, the state of Florida funded a comprehensive tobacco prevention targeted at youth and modeled on the programs in California and Massachusetts. This innovative program that actively involves youth in its design and implementation has produced early success:[23]

- Less than a year after the initiation of Florida's Tobacco Pilot program, current smoking was reduced by 19 percent (3.5 percentage points) among middle school students and 8 percent (2.2 percentage points) among high school students.

- The proportion of Florida middle school students using any form of tobacco (cigarettes, cigars, or spit tobacco) declined by 21 percent from 1998 to 1999. The proportion of high school students using any form of tobacco declined by 8 percent.

After less than five months of Florida's new Tobacco Pilot Program, more than 90 percent of teens in the state were aware of the program, and over half were aware of the campaign logo. The Florida campaign had an immediate impact on teen attitudes regarding smoking, as evidenced by the following:

- From April to September of 1998, the proportion of Florida teens who "strongly agree" that smoking has nothing to do with whether a person is cool increased from 45 to 59 percent.

- From April to September, the proportion of Florida teens who "strongly agree" that tobacco companies try to get young people to smoke because older people quit smoking or die increased from 29 to 42 percent.

Early Success in Oregon

In 1997, the state of Oregon implemented a Tobacco Prevention and Education Program (TEPP) modeled on the California and Massachusetts programs with revenue from a tobacco tax increase. This program has already achieved declines in overall tobacco consumption.[24]

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

- **Preliminary data suggests that the prevalence of adult smoking in Oregon has already declined by 6.4 percent.**

- **Between 1996 and 1998, smoking among pregnant women in Oregon declined by 14 percent (from 17.7% to 15.2%).[25]**

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[1] Pierce, JP et al., *Tobacco Control in California; Who's Winning the War? An Evaluation of the Tobacco Control Program, 1989-1996.* La Jolla, CA: University of California, San Diego; 1998.
[2] *California's Tobacco Control Program: Preventing Tobacco Related Disease and Death*; Tobacco Control Section, California Department of Health Services, April 3,1998.
[3] Pierce, JP et al., "Has the California Tobacco Control Program Reduced Smoking?" *Journal of the American Medical Association*, September 9, 1998. Volume 280, No. 10.
[4] Pierce, JP et al., *Tobacco Control in California; Who's Winning the War? An Evaluation of the Tobacco Control Program, 1989-1996.* La Jolla, CA: University of California, San Diego; 1998.
[5] *Independent Evaluation Consortium. Final Report of the Independent Evaluation of the California Tobacco Control Prevention and Education Program: Wave 1 Data, 1996-1997.* Rockville, Maryland: The Gallup Organization, 1998.
[6] *Independent Evaluation Consortium. Final Report of the Independent Evaluation of the California Tobacco Control Prevention and Education Program: Wave 1 Data, 1996-1997.* Rockville, Maryland: the Gallup Organization, 1998.
[7] *California's Tobacco Control Program: Preventing Tobacco Related Disease and Death*; Tobacco Control Section, California Department of Health Services, April 3, 1998.
[8] Teh-Wei Hu, Hai-Yen Sung, Keeler TE. "Reducing Cigarette Consumption in California: Tobacco Taxes vs an Anti-Smoking Media Campaign." *Am J Public Health* 1995; 85(9):1218-1222.
[9] Chaloupka, FJ and Grossman M. *National Bureau of Economic Research Working Paper, No. 5740, September 1996.*
[10] *California's Tobacco Control Program: Preventing Tobacco Related Disease and Death*; Tobacco Control Section, California Department of Health Services, April 3, 1998.
[11] Pierce, JP et al., *Tobacco Control in California; Who's Winning the War? An Evaluation of the Tobacco Control Program, 1989-1996.* La Jolla, CA: University of California, San Diego; 1998.
[12] Pierce, JP et al., *Tobacco Control in California; Who's Winning the War? An Evaluation of the Tobacco Control Program, 1989-1996.* La Jolla, CA: University of California, San Diego; 1998.
[13] Massachusetts Youth Risk Tobacco Survey: 1999.
[14] Massachusetts Youth Risk Tobacco Survey: 1999.
[15] *Independent Evaluation of the Massachusetts Tobacco Control Program: Fifth Annual Report, January 1994 to June 1998.* Abt Associates, Inc.
[16] *Independent Evaluation of the Massachusetts Tobacco Control Program: Fifth Annual Report, January 1994 to June 1998.* Abt Associates, Inc.
[17] Massachusetts Tobacco Survey: 1993; Massachusetts Adult Tobacco Survey: FY 99
[18] Massachusetts Tobacco Survey: 1993; Massachusetts Adult Tobacco Survey: FY 99
[19] *Independent Evaluation of the Massachusetts Tobacco Control Program: Fifth Annual Report, January 1994 to June 1998.* Abt Associates, Inc.
[20] Massachusetts Tobacco Survey: 1993; Massachusetts Adult Tobacco Survey: FY 99
[21] *Independent Evaluation of the Massachusetts Tobacco Control Program: Fifth Annual Report, January 1994 to June 1998.* Abt Associates, Inc.
[22] Chaloupka, FJ and Grossman M. *National Bureau of Economic Research Working Paper, No. 5740, September 1996.*
[23] *1999 Florida Youth Tobacco Survey*: Volume 2, Report 1; Florida Department of Health, April 15, 1999.
[24] *Decline in Cigarette Consumption Following Implementation of a Comprehensive Tobacco Prevention and Education Program -- Oregon, 1996-1998.* Morbidity and Mortality Weekly Report (MMWR), U.S. Centers for Disease Control and Prevention (CDC), 26 February 1999.
[25] *Tobacco Prevention and Education Program Report – 1999.* Oregon Health Division.

Q. 6 – Who supports effective tobacco prevention?

A.:

(1) THE PEOPLE want effective tobacco prevention work done. A new North Dakota poll indicates that fully 92% of the state's residents want their settlement funds spent on effective tobacco prevention. Released in January, 2001, by Winkelman Consulting of Fargo, the new poll also shows that nearly 7 of every 10 North Dakotans want at least HALF of the settlement money to be so invested. (Please note: The newest poll only confirms numerous previous polls showing how strongly the public wants Tobacco Settlement dollars spent on what they were originally intended for. Nearly-identical results were obtained in an earlier North Dakota poll in 1998; in a nationwide poll in 1999; and in a South Dakota poll in 1999.)

(2) The health science AUTHORITIES (including the most respected agencies and experts both statewide and nationwide) are almost unanimously advocating for science-based, comprehensive tobacco prevention programs.

***Please refer to attached:**
–"Consensus: Use Tobacco Settlement Money for Comprehensive, Accountable Tobacco Prevention"
–"Statewide Poll on the Use of Tobacco Settlement Funds-Winkelman Consulting"

Consensus: Use Tobacco Settlement Money for Comprehensive, Accountable Tobacco Prevention

FACTS:

(1) The PEOPLE overwhelmingly support directing a major portion of Tobacco Settlement dollars to mount **sustainable, comprehensive tobacco prevention programs.** Just last month a **new statewide poll** demonstrated that by an overwhelming margin, (92%) North Dakota residents want their settlement funds spent on effective tobacco prevention. The survey was conducted Jan. 4-8, 2001, by Winkelman Consulting of Fargo. The new poll also shows that nearly 7 of every 10 North Dakotans want at least HALF of the money to be so invested. It's important to note that the Winkelman poll emphatically confirms numerous previous polls showing how strongly the public wants Tobacco Settlement dollars spent on what they were originally intended for: Nearly-identical results were obtained in an earlier North Dakota poll in 1998; in a nationwide poll in 1999; and in a South Dakota poll in 1999.

(2) The health science community (including the following partial list) is with virtual unanimity advocating for science-based, comprehensive tobacco prevention:

- **U.S. Centers for Disease Control and Prevention (CDC)**
- **U.S. Surgeon General**
- **Institute of Medicine (IOM)**
- **National Cancer Institute (NCI)**
- **American Public Health Association (APHA)**
- **American Medical Association (AMA)**
- **Association of State and Territorial Health Officials (ASTHO)**
- **National Association of County and City Health Officials (NACCHO)**
- **National Association of Local Boards of Health (NALBOH)**
- **American Lung Association (ALA)**
- **American Heart Association (AHA)**
- **American Cancer Society (ACS)**
- **North Dakota Medical Association *****
- **North Dakota Nurses' Association *****
- **N.D. Chapter of the American Academy of Family Physicians *****
- **N.D. Chapter of the American Academy of Pediatrics *****
- **N.D. Chapter of the American College of Physicians-American Society of Internal Medicine *****
- **N.D. Attorney General's Blue Ribbon Tobacco Panel *****

Samples of policies urging implementation of Coordinated, Comprehensive, Sustainable Tobacco Prevention:

"CDC recommends that States establish tobacco control programs that are comprehensive, sustainable, and accountable. This document draws upon 'best practices' determined by evidence-based analyses of comprehensive State tobacco control programs...it is equally critical to recognize why (the 9) individual components must work together to produce the synergistic effects of a comprehensive program."

--Best Practices for Comprehensive Tobacco Control Programs,
Centers for Disease Control and Prevention (Aug., 1999) → →

"The single most promising public health intervention today is not the development of a new drug but the opportunity to invest part of the recent $246 billion settlement...into...proven programs that would prevent our nation's children from smoking. ... there can be no greater priority to public health, community health or family health in this country than ensuring a robust and comprehensive tobacco control program in every state."
--U.S. Surgeon General David Satcher, *The Washington Post*, May 25, 1999

"Multifaceted state tobacco control programs are effective in reducing tobacco use. Tobacco control programs can reduce tobacco use, thus saving lives...To ensure accountability and enable future improvements in tobacco control programs, state tobacco control programs must be evaluated and have explicit goals coupled to performance measures."
--Institute of Medicine and National Research Council's *State Programs Can Reduce Tobacco Use*

"The American Public Health Association...Urges that a substantial percentage of any monies received by national, state, and local public entities as a result of tobacco litigation (past and future) be allocated to implementation of evaluation of comprehensive tobacco control and prevention programs, following the guidelines outlined by CDC; (and) Encourages APHA state and local affiliates to advocate for these policies before state legislatures and governors and, where appropriate, to participate in coalitions that support these policies;"
--Policy Statements by the Governing Council of the American Public Health Association, Nov. 10, 1999

"Advocate for significant, sustained funding for comprehensive tobacco prevention and control programs at the federal, state and local levels... "Advocate for a significant portion of tobacco settlement funds to be used in your state to fully implement a comprehensive tobacco prevention and reduction plan..."
--*Tobacco Settlement Action Brief* and
ASTHO, NACCHO, NALBOH *Joint Policy Statement on Tobacco Control*, 1999

"The $206 billion tobacco industry settlement with the states' Attorneys General, signed in November of 1998, represents only a small portion of the actual past and anticipated future Medicaid costs related to tobacco. The public sector now has an historic opportunity to impact future health care expenditures and save lives by applying a significant portion of those dollars towards reducing and preventing tobacco use. Local governments have a statutory responsibility to address tobacco use as a dominant threat to the health of their communities. ... The *Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs* builds on CDC's recommendations ... Research and experience indicate that the more money available to support a well-managed, comprehensive tobacco use prevention and control program, the greater the reduction in tobacco use ... At both the state and local levels of government, investing in comprehensive tobacco use prevention and control now will lead to substantial savings in the costs of treating tobacco-related illness in the future ... Evidence from tobacco control programs in California, Massachusetts, Oregon, and Florida indicate that the most successful approaches to reducing tobacco use and exposure to environmental tobacco smoke feature a multi-faceted, community-based strategy..."
--*Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs*,
National Association of County and City Health Officials, Dec., 1999

In its *The Concerned Board of Health Members' Guide to Tobacco Control Advocacy*, the NALBOH urges its members to "establish a position on where the tobacco settlement dollars should be spent in your state –on comprehensive tobacco prevention programs, not road repair..."

"Use of State Tobacco Settlement Dollars. States sued the tobacco industry because they said they had a tobacco problem. Well, if states don't use that money to fix their tobacco problem, maybe morgue construction is the best way to spend the money, because approximately 1.2 million kids start smoking each year. The only way to break the deadly cycle of tobacco use is to use the settlement..."
--Statement of M.Cass Wheeler, CEO, American Heart Association, April 29, 1999

Hon Mr. Chairman & members of the Committee -
I would like to speak to SB2380 from the Traditional Indian perspective.
In my language, tobacco is chuŋlí" (nasal "n"), & it is sacred. Chuŋlí's function is to carry prayers to Tunkashila, the Grandfather aspect of the Creator, & the Spirits — Therefore, it should never be smoked casually, but only with respect & in a prayerful way. Our Traditions all teach that if the very powerful spirit that is called "chuŋlí" is not shown proper respect, it will retaliate by taking over your will & eating your lungs — & so teach you why you should have shown respect. This pretty well describes tobacco addiction & lung cancer & emphysema .... So I ask you to include this Traditional teaching in all programs you form to deter casual smoking — while keeping in mind our religious Rights & necessity of Chuŋlí to them & protecting our sacred tobacco & Rights.
Thank you for hearing me -

Carl Two Eagles - Lakota Traditionalist,
Sun Dancer, Pipe Keeper

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CAMPAIGN for TOBACCO-FREE Kids

RAISING STATE TOBACCO TAXES ALWAYS REDUCES TOBACCO USE (AND ALWAYS INCREASES STATE REVENUES)

For over 15 years, economic research studies have consistently documented the fact that cigarette price increases reduce smoking, especially among kids. These studies currently conclude that every 10 percent increase in the real price of cigarettes will reduce the total amount of adult smoking by about four percent and reduce teen smoking by roughly seven percent.[1] Over the past decade or so, many states have raised their cigarette tax rates and, as the economic research predicts, the tax increases reduced cigarette consumption in each of these states below what it would otherwise have been. Nevertheless, every single one of these states also enjoyed increased cigarette tax revenues, despite the reductions in smoking and cigarette sales. Put simply, in every state the revenue losses from fewer cigarette sales were more than made up for by the increased state revenues per pack.

Recent State Experiences With Tobacco Tax Increases

State	Date	Tax Increase Amount (per pack)	New Tax (per pack)	Consumption Decline (percent)	Revenue Increase (percent)	New Revenues (millions)
Alaska	1997	71¢	$1.00	-13.5%	+202%	$28.7
Hawaii	1998	20¢	$1.00	-8.1%	+19.9%	$6.4
Illinois	1997	14¢	58¢	-8.9%	+19.0%	$77.4
Maine	1997	37¢	74¢	-15.5%	+66.7%	$30.8
Maryland	1999	30¢	66¢	-16.3%	+53.9%	$69.0
Massachusetts	1996	25¢	76¢	-14.3%	+28.0%	$64.1
Michigan	1994	50¢	75¢	-20.8%	+139.9%	$341.0
New Jersey	1998	40¢	80¢	-16.8%	+68.5%	$166.6
Oregon	1997	30¢	78¢	-8.3%	+77.0%	$79.8
Rhode Island	1997	10¢	71¢	-1.5%	+16.2%	$8.6
South Dakota	1995	10¢	33¢	-5.6%	+40.4%	$6.1
Utah	1997	25¢	51.5¢	-25.7%	+42.4%	$12.7
Vermont	1995	24¢	44¢	-16.3%	+84.2%	$11.7
Wisconsin	1997	15¢	59¢	-6.5%	+25.8%	$52.9

Sources: Orzechowski & Walker, *Tax Burden on Tobacco* (2000) [a tobacco industry funded compilation of state tobacco tax, price, and revenue data]; Maryland data from State Comptroller's Office. Consumption declines and revenue increases calculated from the full fiscal year before the tax increase to the full year after the tax increase.

Complete data from California and New Hampshire, which increased their cigarette taxes in 1999, are not yet available. But newspaper reports noted that in the six months after California raised its tax by an additional 50 cents per pack (to 87 cents per pack), state cigarette sales fell by 30 percent compared to same six months in 1998 while revenues increased.[2] In addition, the early evidence from New York state -- which raised its cigarette taxes by 55 cents to $1.11 per pack (the highest rate in the country) in March 2000 -- shows that state cigarette sales had dropped by more than 48 percent in the second month after the tax increase compared to the same month a year earlier but the state's cigarette tax revenues had still increased by $1.5 million.[3]

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Cigarette Company Attacks on State Tobacco Tax Increases

Internal tobacco industry documents that have been made public in the various lawsuits against the cigarette companies show that since at least the early 1980s the companies have fully accepted the fact that cigarette tax increases reduce their sales, especially among kids (their replacement customers).[4] Accordingly, it is not surprising that the companies spend millions of dollars to oppose any proposed state tobacco tax increases. But when the cigarette companies argue that state cigarette tax increases will not reduce smoking or that state tobacco revenues will be eroded by cigarette smuggling and cross-border purchases they are ignoring the firmly established fact that *every single state that has significantly increased its cigarette taxes has experienced both reduced cigarette sales and increased state revenues.*

Despite this fact, 36 states have not increased their cigarette tax rates for at least five years, and 17 of those states not having increased their cigarette taxes for ten years or more. Six states have not increased their cigarette taxes since the 1970s or 1960s. In most cases, state cigarette tax rates have been substantially eroded by inflation -- and now constitute a much smaller percentage of the total price of a pack of cigarettes -- compared to when they were first passed into law.

The National Center for Tobacco-Free Kids, September 11, 2000

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[1] See, e.g., Chaloupka, F. J., "Macro-Social Influences: The Effects of Prices and Tobacco Control Policies on the Demand for Tobacco Products," *Nicotine and Tobacco Research* (forthcoming); Chaloupka, F. J. & R. Pacula , *An Examination of Gender and Race Differences in Youth Smoking Responsiveness to Price and Tobacco Control Policies*, National Bureau of Economic Research, Working Paper 6541 (April 1998). See, also, Gruber, J. & J. Zinman, "Youth Smoking in the U.S.: Evidence and Implications," National Bureau of Economic Research Working Paper No. 7780 (July 2000); Purcell, W. D., *Changing Prices, Changing Cigarette Consumption*, Virginia Tech Rural Economic Analysis Program (May 1999); Evans, W.N., and L.X Huang, "Cigarette Taxes and Teen Smoking: New Evidence from Panels of Repeated Cross-Sections," Manuscript, Department of Economics, University of Maryland (1998); Credit Suisse, "Sensitivity Analysis on Cigarette Price Elasticity," First Boston Corporation (December 1998); Evans, W. N. & L. X. Huang, *Cigarette Taxes and Teen Smoking: New Evidence from Panels of Repeated Cross-Sections*, working paper (April 15, 1998);Harris, J. E. & S. W. Chan, "The Continuum-of-Addiction: Cigarette Smoking in Relation to Price Among Americans Aged 15-29," *Health Economics Letters* 2(2) 3-12 (February 1998); U.S. Centers for Disease Control and Prevention (CDC), "Responses to Cigarette Prices By Race/Ethnicity, Income, and Age Groups -- United States 1976-1993," Morbidity and Mortality Weekly Report 47(29): 605-609 July 31, 1998); Institute of Medicine, *Taking Action to Reduce Tobacco Use*, the National Academy of Sciences (1998); Chaloupka, F. J. & M. Grossman, "Cigarette Taxes: The Straw to Break the Camel's Back," *Public Health Reports* 112(4): 291-97 (July/August 1997); Lewitt, E.M., A. Huland, N. Kerrebrock, and K.M. Cummings, "Price, Public Policy and Smoking in Young People," *Tobacco Control*, 6(S2)"17-24 (1997); Chaloupka, F.J., and M. Grossman, "Price, Tobacco Control Policies, and Youth Smoking," National Bureau of Economic Research Working paper Number 5740 (1996); National Cancer Institute, *The Impact of Cigarette Excise Taxes on Smoking Among Children and Adults: Summary Report of a National Cancer Institute Expert Panel* (1993); Lewit, E.M., and D. Coate, "The Potential for Using Excise Taxes to Reduce Smoking, " *Journal of Health Economics*, 1(2):121-54 (;982).

[2] See, e.g., Reuters, "California Cigarette Sales Plunge After New Tax" (September 13, 1999).

[3] Odato, J., "Cigarette Sales Sink Under Hefty Tax," *Albany Times Union* (May 25, 2000).

[4] See, e.g., Philip Morris Executive Jon Zoler, "Handling An Excise Tax Increase," (September 3, 1987), PM Bates Number: 2068122240/2241; R.J. Reynolds Executive D. S. Burrows, "Estimated Change In Industry Trend Following Federal Excise Tax Increase" (September 20, 1982), RJR Bates Number 500045052 -5132; Philip Morris Research Executive Myron Johnston, "Teenage Smoking and the Federal Excise Tax on Cigarettes" (September 17, 1981), PM Bates Number: 2001256224/5227.

CAMPAIGN for TOBACCO-FREE Kids

For Immediate Release
September 11, 2000

Contact: Joel Spivak/Vince Willmore
202-296-5469

Statement By
Matthew L. Myers, President
CAMPAIGN FOR TOBACCO-FREE KIDS
Re: New Study Shows Higher Cigarette Taxes Would Result in Fewer Smokers, Fewer Tobacco-Related Deaths

Washington, D.C. (September 11, 2000) – A new study, published today in the journal *Preventive Medicine*, clearly demonstrates the beneficial effects of raising taxes on cigarettes. The study, co-authored by researchers from the Pacific Institute for Research and Evaluation and the Roswell Park Cancer Institute, shows that an increase of $1 in the current cigarette excise tax, indexed for inflation, would result in 2.3 million fewer smoking-related deaths over the projected 40-year period the study measures.

The greatest benefit from the tax hike would be to youth smokers who are, as a group, the most sensitive to price fluctuations. The study projects that a $1 cigarette tax hike would immediately decrease youth smoking by 30 percent while reducing overall smoking rates by 11 percent.

This study sends a strong message to federal and state legislators that cigarette tax increases are a powerful tool they can and should use to save lives. Currently, 36 states have not raised their cigarette taxes for at least the past five years, 17 states have not raised cigarette taxes in at least ten years, and six states have not raised cigarette taxes in twenty years or more.

The CAMPAIGN FOR TOBACCO-FREE KIDS urges state legislators to heed the results of this new study and immediately enact legislation to raise their states' cigarette tax. States that have recently done so, like New York and California, have seen tax revenues increase while consumption has dropped. Those states should serve as a model for the rest. As the new study points out, raising cigarette taxes now will save millions of lives and millions of dollars in public health costs. To do anything less is simply myopic.

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Prepared by the North Dakota Legislative Council staff for Senator Holmberg
March 2001

SB 2380
3-29-01

ALCOHOL, DRUG, AND TOBACCO PROGRAM FUNDING SURVEY - 2001-03 BIENNIUM

The schedule below lists the funding included in the 2001-03 executive budget identified by select state agencies that will be used for alcohol, drug, and tobacco prevention and treatment programs:

Agency	General Fund	Federal and Special Funds	Total Funds
Attorney General's Office			
D.A.R.E. (Drug Abuse Resistance Education) - A children's educational program aimed at preventing drug use, usually conducted in grades 5 and 6		$15,000	$15,000
CounterAct - Drug prevention programs aimed at grades 4 through 6. The fund is used to train local law enforcement officers and to provide classroom materials.		90,000	90,000
Residential substance abuse treatment for state prisoners grant - A passthrough grant for addiction treatment of state prisoners		564,557	564,557
Narcotics section - Includes all the state's drug task forces and investigations of drug crimes, dealers, and manufacturers	$3,287,499		3,287,499
Marijuana eradication - A federal grant used for marijuana enforcement and elimination		200,000	200,000
Midwest high-intensity drug trafficking area - A federal grant aimed at the growing methamphetamine problem in this region		2,049,064	2,049,064
Edward Byrne memorial state and local law enforcement assistance formula grant program - Federal funding used at the state and local level for anti-drug abuse programs		6,917,216	6,917,216
Total Attorney General's office	$3,287,499	$9,835,837	$13,123,336
Department of Corrections and Rehabilitation			
Drug court - An adult services program in Burleigh and Morton Counties that handles drug (90%) and driving under the influence (DUI) (10%) cases	$58,617	$175,850	$234,467
Alternatives to incarceration - Programs providing alternatives to incarceration, including halfway houses, treatment, and home reporting	2,900,000[1]	[1]	2,900,000[1]
Department of Corrections and Rehabilitation juvenile services grants - Title II and Title V juvenile delinquency prevention grants and the juvenile accountability incentive block grant (JAIBG). The majority of this funding is provided to political subdivisions for juvenile programs and are not required to be used for drug or alcohol programs. (This amount is an estimate from the department and depends on the federal grants available.)		1,700,000	1,700,000
Mental health unit - Conducts assessments and provides treatment for inmates with addiction problems	886,676		886,676
Youth Correctional Center treatment program - Provides treatment services for youth	93,000		93,000
Total Department of Corrections and Rehabilitation	$3,938,293	$1,875,850	$5,814,143
State Department of Health			
Community health trust fund - Funding used for tobacco prevention programs		$5,000,000	$5,000,000
Centers for Disease Control and Prevention - Federal funding used for tobacco prevention programs		2,369,934	2,369,934
Total State Department of Health		$7,369,934	$7,369,934

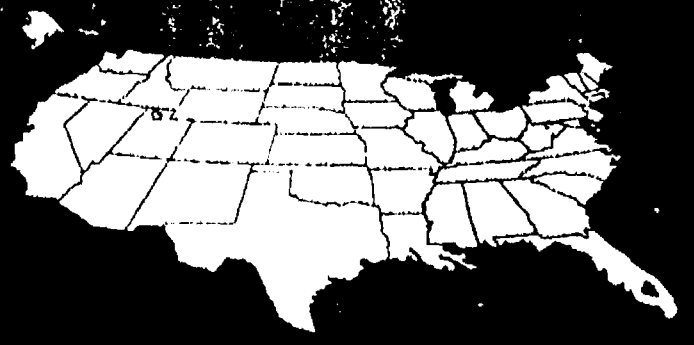
Agency	General Fund	Federal and Special Funds	Total Funds
Department of Human Services			
Prevention and treatment services - Prevention and treatment services provided at the human service centers, State Hospital, and Developmental Center	$7,528,643	$15,994,508	$23,523,151
Governor's fund for safe and drug-free schools and communities - Funding is provided as grants to high-risk areas for enforcement and education.		857,000	857,000
Department of Justice underage drinking grant - Funding is used for underage drinking prevention programs.		720,000	720,000
Native American youth alcohol and drug prevention program - Funding is used for youth alcohol and drug prevention programs for Native Americans.		200,000	200,000
Total Department of Human Services	$7,528,643	$17,771,508	$25,300,151
Department of Public Instruction			
Title V drug-free school program - Funding for reducing drug, alcohol, and tobacco use through education and prevention activities		$3,428,692	$3,428,692
Department of Transportation			
402 highway traffic safety - Funding is used for fake ID training, teen court, students against drunk driving, and the cops-in-shops programs.		$312,000	$312,000
410 alcohol incentive grant - Funding is used for alcohol countermeasure activities and other programs discouraging drinking and driving.		500,000	500,000
Total Department of Transportation		$812,000	$812,000
Supreme Court			
Juvenile drug court - Funding is used for a youth treatment program to intervene in alcohol and drug use through court intervention.	$33,466	$264,640	$298,106
National Guard			
State military operations - Funding is used for a number of programs, including education programs and the counter drug fly program that assists law enforcement by utilizing military helicopters in drug enforcement efforts.		$2,352,000[2]	$2,352,000[2]
Grand Total	$14,787,901	$43,710,461	$58,498,362

[1] The department was unable to provide the funding for these programs by funding source. The department indicated that the majority of the funds are from the general fund.

[2] The amount shown is based on the National Guard's federal fiscal year 2001 funding allocation also being available at the same level for federal fiscal year 2002.

Investment in Tobacco Control

State Highlights 2001



U.S. Department of Health and Human Services

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Office on Smoking and Health

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1999 North Dakota
Youth Risk Behaviors

Healthy kids make better students.
Better students make healthy communities.

–Association for State and Territorial Health Officials
–Council of Chief State School Officers

Tobacco

Alcohol and Drug Use **Drinking and Driving**

Dietary Behaviors **Physical Activity** **Body Image**

Suicide **Violence** **Seat Belts**

STDs **Sexual Behavior** **HIV/AIDS**

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North Dakota

Tobacco Use Prevention and Dependence Treatment Plan

the BLUE RIBBON tobacco panel

December 2000