Center for Public Health
and Tobacco Policy

Advancing Tobacco Control: The Known, the New and the Next

Findings of the 2014 Surgeon General's Report

This work provides educational materials and research support for policy initiatives and does not constitute and cannot be relied upon as legal advice.

The Center for Public Health & Tobacco Policy

Contact:
Phone: 617-373-8494
tobacco@tobaccopolicycenter.org
www.tobaccopolicycenter.org

The Center for Public Health and Tobacco Policy is a resource for the New York and Vermont tobacco control communities. It is funded by the New York State and Vermont Departments of Health and works with the New York State and Vermont Tobacco Control Programs, the New York Cancer Prevention Program, as well as the programs' contractors and partners to develop and support policy initiatives that will reduce the incidence of cancer and tobacco-related morbidity and mortality in New York and Vermont.

Table of Contents

Advancing Tobacco Control: The Known, the New and the Next
Findings of the 2014 Surgeon General's Report

The U.S. Surgeon General provides Americans with the best scientific information available on how to improve their health and reduce the risk of illnes and injury. In 1964, the Office of the Surgeon General published its first report on Smoking and Health. The report concluded that cigarette smoking causes lung cancer and other diseases, dramatically shifting the social and policy context of smoking. By carefully and objectively reviewing the available scientific evidence, the report established that the link between smoking and disease was clear and irrefutable, despite the industry's continued denials.

Since then, other Reports of the Surgeon General have identified not only the death and disease caused by tobacco use, but also the factors that contribute to the tobacco epidemic. In 1986, for example, the Surgeon General's Report concluded that "the judgment can now be made that exposure to environmental tobacco smoke can cause disease, including lung cancer, in nonsmokers." In 2012, the Surgeon General's Report concluded that the "[a]dvertising and promotional activities by tobacco companies have been shown to cause the onset and continuation of smoking among adolescents and young adults." These subsequent reports further demonstrated to the public that the industry's denials (in these cases about the effects of secondhand smoke and the intentional marketing to youth) were simply not credible.

50 years after the first report, the 2014 Surgeon General's Report recounts the vast evidence that tobacco use causes devastating illness and disease, and newly identifies several diseases causally linked to tobacco use and exposure to tobacco smoke. The report describes the success of tobacco control policies in reducing tobacco use and the tobacco industry actions that have undermined them. Additionally, the report reiterates the evidence-based policies that, if implemented at their most effective levels, can accelerate our progress by preventing initiation of smoking by youth and increasing successful quit attempts. Finally, the report provides evidence supportive of the enormous potential of innovative tobacco control policies and identifies certain "end game" strategies, including state and local tobacco sales restrictions that could once and for all eliminate the tobacco epidemic.

Smoking remains the leading preventable cause of premature disease and death in the United States. This report echoes a previous Surgeon General conclusion that "we have evidence-based strategies and tools that can rapidly drop youth initiation and prevalence rates down into the single digits." Since "virtually all smoking begins before 18 years of age," one of the goals of tobacco control is to stop youth initiation of tobacco use. More effective use of known tobacco control strategies, and the implementation of new strategies that draw on our enhanced knowledge of what works and what is feasible at the state and local levels will not only help us meet this goal, but will help those who already use tobacco products to successfully quit and reduce their risk of disease and death. We hope that this presentation of the Surgeon General's findings will be a useful and effective resource for those working toward a tobacco-free society.

Center for Public Health and Tobacco Policy

Notes For Reader:

This publication is intended for policymakers and community educators engaging in tobacco control initiatives. Information presented by the U.S. Surgeon General represents the best scientific information available to protect, promote and advance the health of our nation, and is a therefore an essential policy tool. Accordingly, we have compiled select excerpts from *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General* (and the Report's executive summary) for easy reference. The excerpts are presented verbatim, but have been selected and reorganized by subject in a manner we believe most helpful to our intended audience.

In our excerpts of the Surgeon General's findings we exclude internal citations and include clarifying statements in brackets where necessary. Additionally, we have used ellipses wherever we have omitted words (other than a reference) within a quoted passage. Each quoted passage in our report contains a number in parentheses; this number indicates the page on which the quote may be found in the original Surgeon General report or executive summary.

We have emphasized certain language within the quoted passages using bold text to highlight certain evidence or conclusions that may be of particular interest to the reader. This emphasis does not appear in the original Surgeon General's Report.

The Surgeon General's Report and (and therefore our excerpts thereof) generally use the terms "adolescents," "children," and "youth" to refer to those between 11 and 17 years old. The reports use the term "young adults" to refer to those between 18 and 25 years old.

With our audience in mind, we include the Surgeon General's discussion of tobacco control strategies with proven effectiveness. Likewise, we omit discussion of certain "end game" strategies, including the report's inconclusive discussion on the role of new non-combusting products rapidly entering the marketplace. The Surgeon General cautions that public health will benefit first and foremost "in an environment where the appeal, accessibility, promotion, and use of cigarettes and other combusted tobacco products are being rapidly reduced."(874) The full text of the Surgeon General's Report can be downloaded from www.surgeongeneral.gov.

The reader will notice references to the Racketeer Influenced and Corrupt Organizations Act (RICO) throughout both the Surgeon General's Report and this guide. These references largely have been taken from the 2006 opinion of U.S. District Court Judge Gladys Kessler in the case of *United States vs. Philip Morris et al.* in which the major U.S. tobacco companies were found to have violated the federal RICO statute. RICO is a law originally enacted to combat organized crime. Specifically, the law permits the prosecution and imposition of civil penalties for racketeering, including certain fraudulent activities. The tobacco industry is the only legal industry to have been pursued and convicted under the statute. More information about this case may be found through the Tobacco Control Legal Consortium, including a summary of the major conclusions of the court.

An index has been inserted at the beginning of each section to guide the reader to subtopics of particular interest. Moreover, we have inserted our own language to give the excerpts context to better guide tobacco control advocates and policymakers looking to support their community education efforts.

Section I.

Tobacco Remains a Major Public Health Threat

Since the publication of the first Surgeon General's Report on Smoking and Health 50 years ago, the tobacco control movement has achieved great success in reducing the prevalence of tobacco use. As a result, nearly eight million premature smoking-related deaths have been averted.

Nevertheless, tobacco use rates remain unacceptably high. Nearly half a million people die each year from smoking-related illness in the U.S.. Moreover, tobacco use disproportionately affects our most vulnerable communities. In fact, 90% of adult smokers started smoking before they reached the age of 18—before they were mature enough to appreciate the risks.

Over the last 50 years, our understanding of the health effects of tobacco use—particularly the use of cigarettes—has evolved. With this report, the Surgeon General actually adds to the long list of diseases and health conditions associated with smoking. Much of this knowledge has been the basis for regulatory actions designed to reduce the devastating effects of tobacco on public health, but these actions have not implemented tobacco controls at their most effective levels.It is imperative that we build on the successes of the last 50 years and accelerate the impact of tobacco control to end the tobacco epidemic.

Tobacco Remains a Major Public Health Threat

Tobacco is the cause of one of public health's greatest catastrophes—and has led to one of its greatest successes.

> For the United States, the epidemic of smoking-caused disease in the twentieth century ranks among the greatest public health catastrophes of the century, while the decline of smoking consequent to tobacco control is surely one of public health's greatest successes. (ES-1)

Scientific research has exposed the terrible consequences of smoking. It has also identified effective tobacco controls, including fully-funded comprehensive tobacco control programs at the state and local levels, mass media campaigns, smoke-free air policies, optimal tobacco excise taxes and barrier-free cessation treatment. Implementation of many of these tobacco control policies has led to substantial declines in smoking.

Tobacco control policies have saved millions of lives.

> Since the first Surgeon General's report in 1964, significant progress has been made in mitigating the tobacco-caused epidemic of disease and premature death. **This progress has been accomplished through the implementation of effective tobacco control programs and policies focused on prevention and cessation. (**857)
>
> To date, tobacco control strategies have cut the prevalence of cigarette smoking by nearly 60%, per capita consumption is one-fourth of what it was at the dawn of the antismoking era, and relative to the size of the population, the disease toll of tobacco in the United States has declined substantially. It has been estimated that this decline in smoking since 1964 was associated with the avoidance of 8 million premature smoking-attributable deaths, with 157 million life years saved. The analysis also demonstrated that tobacco control since 1964 had an important impact on the life expectancy of U.S. adults, contributing an increase of 2.3 years for males and 1.6 years for females, or about 30% of the overall national increase in life expectancy over the period 1964–2012. (856)
>
> Per capita cigarette consumption has declined by 72% from 4,345 cigarettes in 1963 to 1,196 in 2012. (867)
>
> The prevalence of current smoking among adults has declined from 42.7% in 1965 to 18.1% in 2012. (867)
>
> The prevalence of high school students who currently smoke declined from 36.4% in 1997 to 18.1% in 2011, the lowest level since the start of national surveys. (867)

Notwithstanding the success of tobacco control, tobacco use remains a significant danger to public health.

Despite the success of tobacco control efforts to reduce tobacco use, and the subsequent knowledge of which tobacco control policies are most effective, smoking remains the leading preventable cause of premature disease and death in this country. Tobacco controls have not been implemented at their most effective levels. Prevalence rates remain unacceptably high—in fact, initiation rates are rising among our youth and young adults. This has a devastating impact on health—particularly among disadvantaged groups—and economically burdens both individuals suffering the health effects of tobacco and the public.

[C]igarette smoking remains the chief preventable killer in America, with more than 40 million Americans caught in a web of tobacco dependence. Each day, more than 3,200 youth (younger than 18 years of age) smoke their first cigarette and another 2,100 youth and young adults who are occasional smokers progress to become daily smokers. (Exec. Summ. Message from Howard Koh)

Nearly one-half million adults still die prematurely from tobacco use each year. (867-9)

Many premature deaths have been avoided because of tobacco control programs, but many more could have been avoided if smoking prevalence had dropped more rapidly when the early warnings of lung cancer risk were widely reported in 1950. (33)

Tobacco has killed more than 20 million people prematurely since the first Surgeon General's report in 1964. The findings in this report show that the decline in the prevalence of smoking has slowed in recent years and that burden of smoking-attributable mortality is expected to remain at high and unacceptable levels for decades to come unless urgent action is taken. (i)

Despite [success in reducing cigarette smoking through tobacco control] over the half century since 1964, **for each of the 8 million premature smoking-attributable deaths averted, two deaths were caused by smoking**. … "[N]o other behavior comes close to contributing so heavily to the nation's mortality burden." (856-7)

Although the prevalence of smoking has declined significantly over the past half century, risks for smoking-related disease and mortality have not. In fact, **today's cigarette smokers—both men and women—have a much higher risk for lung cancer and chronic obstructive pulmonary disease than smokers in 1964, despite smoking fewer cigarettes**. (869)

[D]ata suggest that **declines in cigarette smoking may be masking persistently high cigarette initiation rates**. **Overall, 2.3 million persons 12 years of age or older initiated cigarette use in 2012, a level equivalent to that observed in 2005**. (750)

Significant disparities in the burden of tobacco use remain.

Disparities in smoking rates persist. Some of the highest prevalence rates are among persons of lower socioeconomic status, some racial/ethnic minority groups, sexual minorities, high school dropouts, and other vulnerable populations including those living with mental illness and substance use disorders. (867-9)

The women most likely to smoke are among the most vulnerable—those disadvantaged by low income, low education, and mental health disorders, further exacerbating the adverse health effects from smoking on mothers and their offspring. Women in these groups are also less likely to quit smoking when they become pregnant and are more likely to relapse after delivery. (461)

A higher prevalence of smoking was noted among youth living below the poverty level than in those living at or above this threshold. (709)

Smoking is a pediatric epidemic—the great majority of adult smokers began smoking before age 18.

Smoking starts during adolescence. This represents a major public health problem for a number of reasons, not the least of which is that adolescents lack the maturity to undertake such an addictive behavior with devastating health effects with any kind of "informed consent."

For each smoker who dies from tobacco-related disease, there are two new, younger replacement smokers. (867-9)

One of the most important—and widely cited—findings from the 1994 and 2012 Surgeon General's reports on smoking and health was that **virtually all cigarette smoking begins before 18 years of age**. Among adults who had ever smoked cigarettes daily, **the mean age (in years) of smoking initiation was 15.3**, and the mean age of beginning to smoke daily was 18.2. Among adults who had ever smoked cigarettes daily, 86.9% had tried their first cigarette by the time they were 18 years of age, while an additional 11.5% did so by 26 years of age**. Virtually no initiation of cigarette smoking (<1.5%) and few transitions to daily smoking (<4.3%) actually occurred in adulthood—that is, after 26 years of age**. Of note, initiation of cigarette smoking often occurred early in adolescence (before 18 years of age); 13.6% of adults who had ever smoked daily began smoking by age 14, before entering high school. (708)

Despite decades of warnings on the dangers of smoking, nearly 42 million adults and more than 3.5 million middle and high school students continue to smoke cigarettes. …The majority (88%) started smoking before 18 years of age, and nearly all first use of cigarettes occurs before 26 years of age. (13)

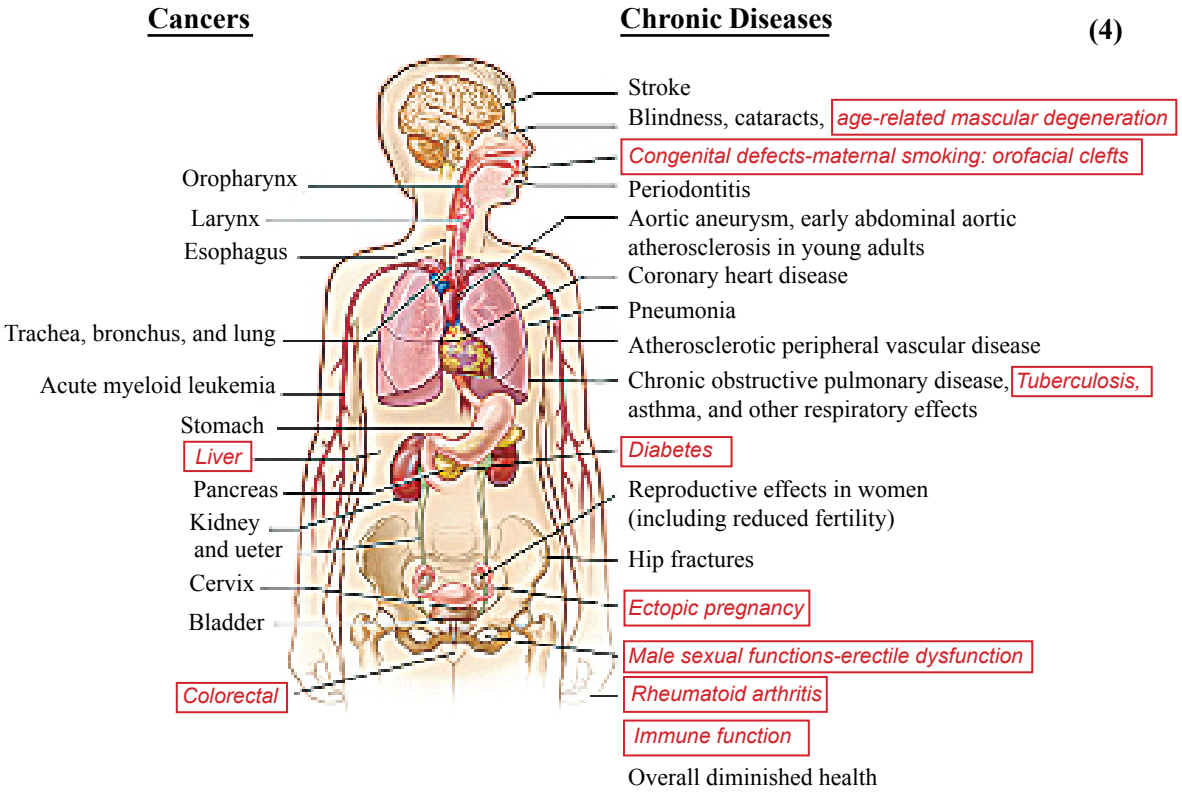
Trends in smoking rates among youth and adults show progress, but the prevalence of current smoking among youth and adults is only slowly declining and **the actual number of youth and young adults starting to smoke has increased since 2002**. (14)

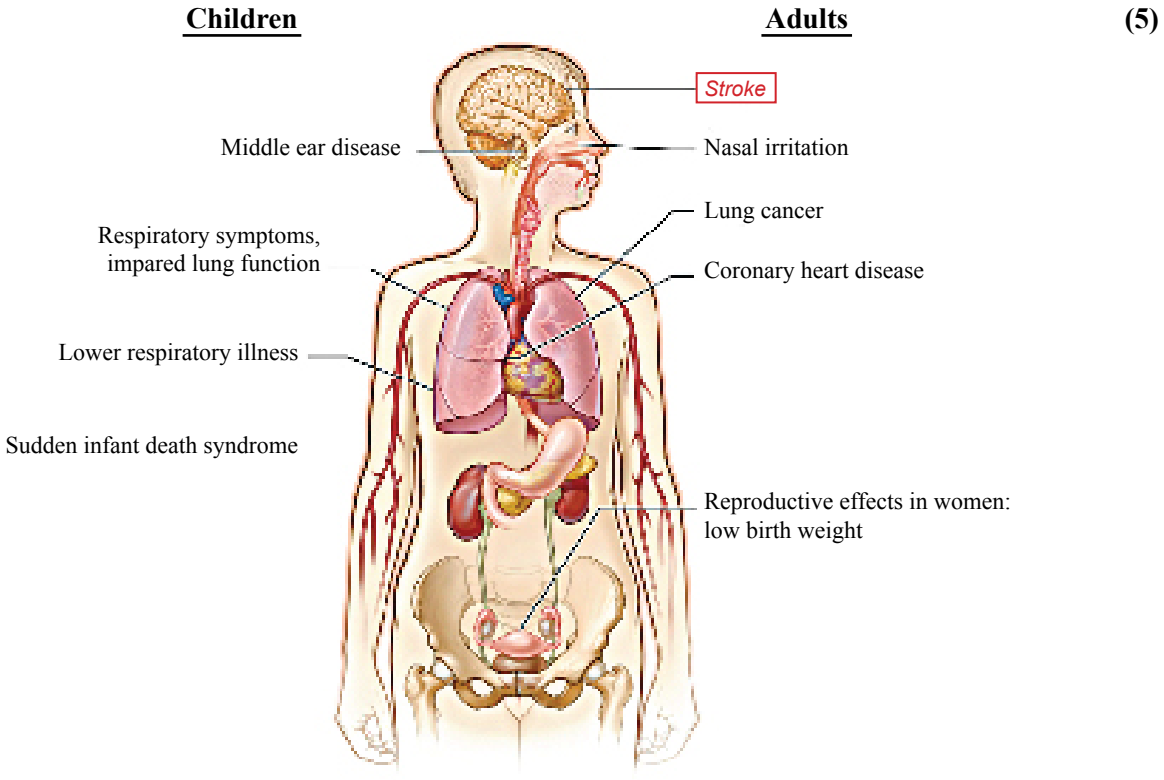
Our knowledge of the health effects of tobacco use has evolved, leading to the identification and implementation of tobacco control policies to reduce tobacco use and improve public health.

Over time, we have developed the evidence that tobacco products—particularly cigarettes—cause significant morbidity and mortality. In fact, the 2014 Surgeon General's report actually *adds* to the list of medical conditions and diseases caused by tobacco use. Moreover, these conditions impose significant economic burdens on tobacco users, businesses and the public.

Since the 1964 Surgeon General's report, cigarette smoking has been causally linked to diseases of nearly all organs of the body, to diminished health status, and to harm to the fetus. Even 50 years after the first Surgeon General's report, research continues to newly identify diseases caused by smoking, including such common diseases as diabetes mellitus, rheumatoid arthritis, and colorectal cancer. (4)

Combustible tobacco products kill users and nonusers alike





(Note: Outlined condition is a new disease that has been causally linked to smoking in this report)

Evidence *suggests* a causal relationship between the following conditions and active or passive smoking, or nicotine exposure:

Type of Illness	Health Condition	Smoking Exposure
Brain Development	Adverse effects for brain development	Nicotine exposure during adolescence
Prostate Cancer	Higher risk of death from prostate cancer	Compared to nonsmokers
Breast Cancer	Breast cancer	Active smoking, tobacco smoke, exposure to secondhand smoke
Asthma	Asthma in adolescents	Active smoking
Asthma	Exacerbation of asthma among children and adolescents	Active smoking
Asthma	Incidence of asthma in adults	Active smoking (as opposed to exacerbation of asthma in adults to which there is a causal relationship)
Tuberculosis	Recurrent tuberculosis	Active smoking
Idiopathic Pulmonary Fibrosis	Idiopathic pulmonary fibrosis	Cigarette smoking
Maternal	Clubfoot, gastroschisis, and atrial septal heart defects.	Maternal smoking in early pregnancy
Maternal	Disruptive behavior disorders among children (in particular, attention deficit hyperactivity disorder)	Maternal prenatal smoking
Maternal	Spontaneous abortion	Maternal active smoking
Dental	Dental caries	Active smoking
Dental	Dental caries in children	Exposure to tobacco smoke
Dental	Failure of dental implants	Cigarette smoking
Digestive	Crohn's Disease	Cigarette smoking
Treatment Response	Poorer response to treatment of certain diseases (including cancer), increased risk of treatment related toxicity, risk of recurrance	Cigarette smoking

The burden of death and disease from tobacco use in the United States is overwhelmingly caused by cigarettes and other combusted tobacco products; rapid elimination of their use will dramatically reduce this burden. (4)

More than 10 times as many U.S. citizens have died prematurely from cigarette smoking than have died in all the wars fought by the United States during its history. (1)
Previous Surgeon General's reports have tracked the evolution of cigarettes into the current highly engineered, addictive and deadly products containing thousands of chemicals that are harmful in themselves, but the burning of tobacco produces the complex chemical mixture of more than 7,000 compounds that cause a wide range of diseases and premature deaths as a result. (ES-1)

The evidence is sufficient to infer that cigarette smoking increases risk for all-cause mortality in men and women [and] that **the relative risk of dying from cigarette smoking has increased over the last 50 years** in men and women in the United States. (641)

Compared with their counterparts in [earlier studies], both men and women in the contemporary cohorts were at greater risk for lung cancer despite smoking fewer cigarettes per day. (161)

Despite declines in the prevalence of current smoking, the annual burden of smoking-attributable mortality in the United States has remained above 400,000 for more than a decade and currently is estimated to be about 480,000, with millions more living with smoking-related diseases. (679)

The lives of smokers are cut short by the development of the many diseases caused by smoking and by their greater risk of dying from common health events, such as complications of routine surgeries and pneumonia. **Smoking shortens life far more than most other risk factors for early mortality; smokers are estimated to lose more than a decade of life**. (7)

Although emphasis has been given to smoking as a cause of specific and avoidable diseases, it is a powerful cause of ill-health generally. These health deficits not only reduce the quality of life of smokers but also affect their participation in the workplace and increase their costs to the health care system. (7)

[Most of the] 20 million Americans [that] have died as a result of smoking since the first Surgeon General's report on smoking and health was released in 1964… were adults with a history of smoking, but **nearly 2.5 million were nonsmokers who died from heart disease or lung cancer caused by exposure to secondhand smoke**. **Another 100,000 were babies who died of sudden infant death syndrome (often referred to as SIDS) or complications from prematurity, low birth weight, or other conditions caused by parental smoking**, particularly smoking by the mother. (1)

The cardiovascular risk attributable to cigarette smoking increases sharply at low levels of cigarette consumption and with exposure to secondhand smoke. (443)

[S]moking continues to cause unacceptable harm to public health. (867-9)

Most data on smoking concerns cigarettes; but cigarettes are not the only combustible game in town anymore.

Using more than one type of combustible tobacco product raises additional concerns about our progress toward ending the epidemic of tobacco-related disease. Although the prevalence of current smoking among adults has declined in recent years, a high percentage of adolescent and young adult cigarette smokers report using more than one tobacco product. The prevalence of adults 18 years of age and older who report smoking cigarettes, cigars, or roll-your-own cigarettes using pipe tobacco presents a much less optimistic picture than looking at the prevalence of cigarette smoking only. (847)

The death and disease caused by smoking or exposure to tobacco smoke imposes significant economic costs to individuals, businesses and the public at large.

In addition to the impact that smoking has on health and well-being, the nation pays enormous financial costs because of smoking. (ES-3)

Although the prevalence of smoking continues to decline in the United States, smoking-related health care expenditures still account for an estimated 5–14% of the total health care expenditures in the United States. (670)

Productivity losses from premature death alone now exceed $150 billion per year. (ES-3)

[T]he value of lost productivity due to premature deaths caused by exposure to secondhand smoke is now estimated to be $5.6 billion per year. (ES-3)

Annual smoking-attributable economic costs in the United States estimated for the years 2009–2012 were between $289–332.5 billion, including $132.5–175.9 billion for direct medical care of adults, $151 billion for lost productivity due to premature death estimated from 2005–2009, and $5.6 billion (in 2006) for lost productivity due to exposure to secondhand smoke. (12)

An estimated] 8.7% of total health care expenditure was attributable to cigarette smoking between 2006–2010. …[S]moking contributed to more than $170 billion in health care expenditures in total [in 2010]. …[R]oughly 3.4% of out-of-pocket health care expenditure (approximately $8.5 billion), 4.4% of private health insurance expenditure (approximately $33.7 billion), 15.2% of Medicaid expenditure (approximately $40.1) billion, or 9.6% of Medicare expenditure (approximately $45 billion) was smoking attributable. In other words, **more than 60% of annual health care expenditures associated with smoking in the United States were reimbursed by public funds, either Medicaid, Medicare, or other federal funds**. (674)

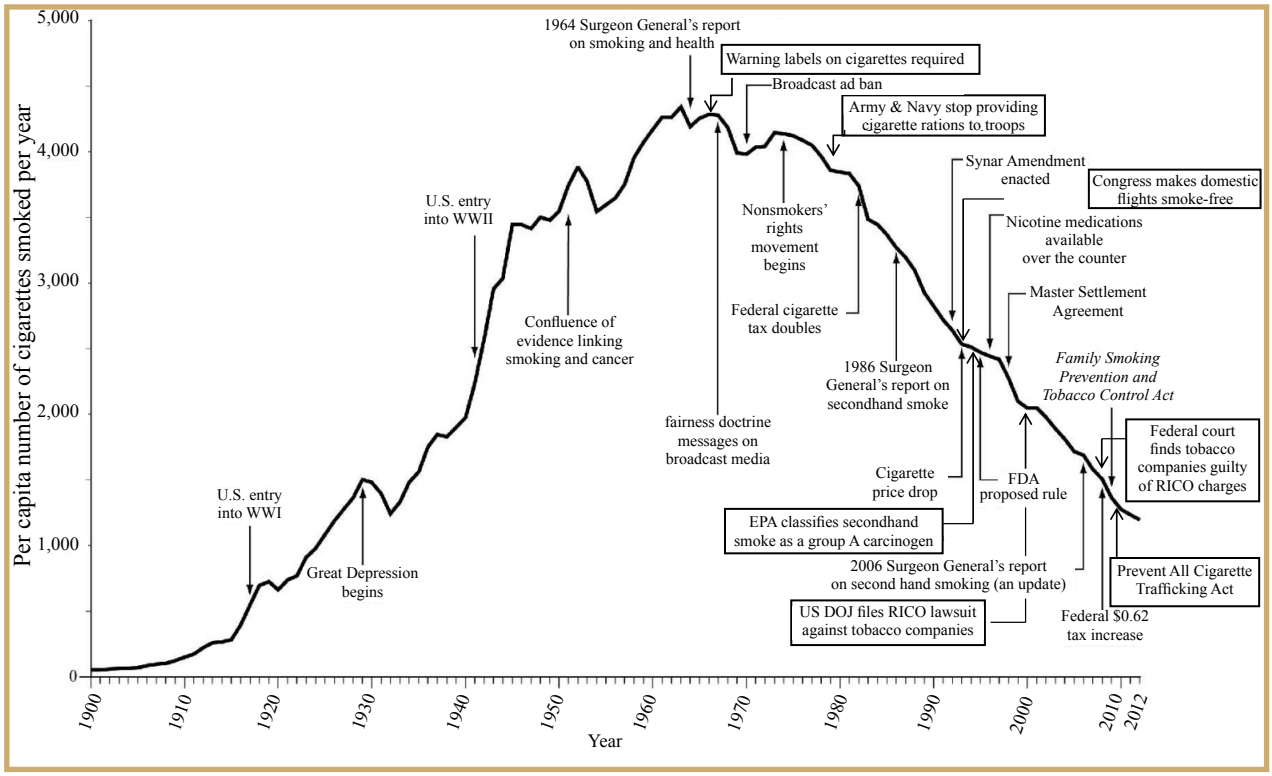
Combustible tobacco products are also responsible for accidental fires. While regulations concerning the design of cigarettes has reduced the incidence of fire (e.g., prohibiting the sale of cigarettes that are not "fire-safe"), these products remain a preventable cause of death, injury and property damage.

The average annual number of deaths attributed to smoking-material fires in homes between 2006–2010 was 620 (336 in males, 284 in females). These fires also caused an estimated 1,570 civilian injuries and $663 million in direct property damage. (665)

As knowledge of tobacco's effect on health has grown, so has the resolve of the public and political leaders to take action.

Fortunately, as research improved the evidence of the incredible harm caused by tobacco, the tobacco control movement grew. Out of this movement came certain regulatory action seeking to reduce tobacco use and the impact of tobacco on public health.

Figure 1. Cigarette Consumption and policy Interventions 1900-2012



(18) (Note: Outlined events added)

The status quo is unacceptable—more must be done to reduce tobacco use and tobacco-related disease.

Declines in tobacco use have stagnated and youth initiation rates are on the rise. Tobacco control policy efforts must be increased to make progress and end the terrible burden of this epidemic.

> Given the urgency of reducing smoking and the only partial success of tobacco control to date, [there must be consideration of] potential additions to [current tobacco control efforts]. Given the growing awareness of the highly lethal and addictive nature of cigarettes, **more dramatic restrictions on the manufacture, distribution, marketing, and sale of tobacco products are being proposed**. (847)
>
> [T]oo many in our nation assume that past success in tobacco control guarantees future progress; nothing can be further from the truth. (Exec. Summ. Message from Howard Koh)

For the future, tobacco control needs to more forcefully impact the burden of avoidable disease and premature death. About one-half of the 42.1 million smokers in the United States in 2012 who continue smoking into later decades of life will die prematurely of a tobacco-related disease, primarily from cigarette smoking. By 2015, tobacco use is expected to be responsible for 10% of all deaths globally. Should such trends continue without any change in interventions and policy, the tobacco epidemic will be prolonged well into the twenty-first century. In fact**, the scope of the epidemic may even increase if any of the tobacco control measures that are in place today are eroded**. (847)

If smoking persists at the current rate among young adults in this country, **5.6 million of today's Americans younger than 18 years of age are projected to die prematurely from a smoking-related illness**. (859)

The burden of smoking-attributable disease and premature death and its high costs to the nation will continue for decades unless smoking prevalence is reduced more rapidly than the current trajectory. (14)

[Assessments of disease burden of smoking-related illnesses] provide compelling evidence that **programs and policies are needed to continue the progress toward ending the tobacco epidemic**. (678)

Section II.

Tobacco Industry Behavior Drives the Tobacco Epidemic

The tobacco industry has deceived the public and undermined public health regulation to maximize profits and sustain its business at the expense of consumers' lives. Tobacco companies have perfected the use of junk science to undermine sound research, deliberately and fraudulently peddled a deadly product, and manipulated the context in which policy debates and public discourse about their product occurs.The industry has engaged in appalling behaior to ensure its products are firmly anchored in society despite evidence that those products are deadly.

While one expects any business to protect its interest, the tobacco industry stands apart by its fraudulent, orchestrated actions, targeting our youth and other vulnerable populations, with lethal consequences. Litigation and investigation have revealed industry documents detailing tobacco companies' strategies, permitting the public—and the courts—a better understanding of the industry's deceptive tactics. With this enhanced understanding, the industry's credibility has diminished and policymakers can make informed decisions about the policies that will best protect public health.

Tobacco Industry Behavior Drives the Tobacco Epidemic

> The tobacco epidemic was initiated and has been sustained by the aggressive strategies of the tobacco industry, which has deliberately misled the public on the risks of smoking cigarettes. (ES-4)

This statement aptly summarizes how the U.S. continues to suffer from the public health disaster of tobacco use 50 years after the first Surgeon General's Report on Smoking and Health sounded alarms for tobacco control. The tobacco industry's deceptive and—at times—illegal tactics in pursuit of profits have driven the tobacco epidemic at the expense of its consumers. The major tobacco companies have systematically wielded their tremendous resources to shape the social context in which their products are evaluated. Moreover, the industry uses those same resources to influence that evaluation—organizing to create doubt about the scientific evidence mounting against them, manipulate the dialogue about their products, design products for maximum addiction (and increased injury), and fraudulently market its "defective" product to vulnerable populations, including—and perhaps most importantly—youth.

> Many factors are responsible for the rapid increase of cigarette smoking, but **the tobacco industry was the central driver** through: (1) development of industrial **technology** enabling cigarette mass production, packaging, and distribution; (2) aggressive **pricing and marketing** combined with positive portrayals of cigarettes in movies—and endorsements by movie stars, sports idols, and even physicians —and including cigarettes in daily rations for soldiers in two World Wars; and (3) widespread industry actions throughout society to advance its interests, including lobbying and using tactics later found to constitute **fraud and racketeering**, such as misleading the public about the risks of smoking. (846)

The tobacco industry uses its tremendous combined resources to drive a public health disaster in the name of profit. Tobacco companies have conspired to thwart meaningful tobacco regulation, manipulate media portrayals of tobacco products, undermine sound science and deceive the public about the lethality of their products.

> [In U.S. v. Philip Morris, the court] found that the tobacco [companies] violated the [*Racketeer Influenced and Corrupt Organizations Act* (the law often used to prosecute organized crime)] by **lying, misrepresenting, and deceiving the** public "including smokers and the young people they avidly sought as 'replacement smokers,' **about the devastating health effects of smoking and environmental tobacco smoke**." … [T]he trial evidence [demonstrated] that the **tobacco industry established an enterprise** "to accomplish the following goals: **counter the growing scientific evidence that smoking causes cancer and other illnesses, avoid liability verdicts** in the growing number of plaintiffs' personal injury lawsuits against [the tobacco companies], and **ensure the future economic viability of the industry**." (800)
>
> The tobacco industry's **extensive campaign to counteract [tobacco control policy interventions] through marketing, public relations, political influence, and creation of doubt about the scientific evidence** on tobacco is now well documented through the industry's internal documents. The industry used its influence to thwart public health action at all levels and **fraudulently misled** the public on many issues, including whether lower-yield cigarettes conveyed less risk to health and whether exposure to secondhand smoke harmed nonsmokers. Undoubtedly, these actions slowed progress in tobacco control. (34)

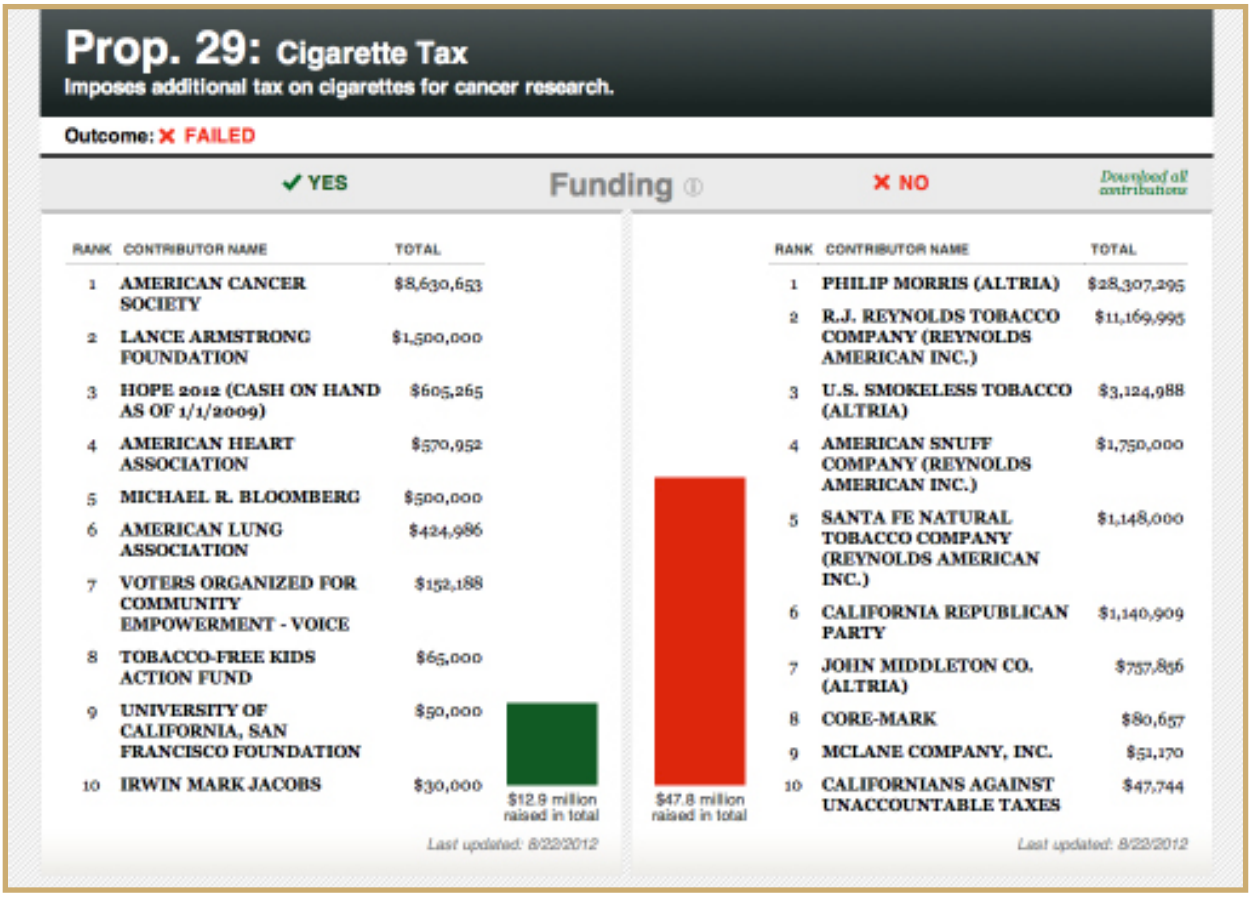
As public health efforts to discourage tobacco use evolved to become broader and stronger over the past half-century, the tobacco industry's strategies changed in parallel in an effort to sustain sales and protect its financial interests. …The summary of the 1981 FTC report documents the **success of the industry's public relations efforts**. The report found that by the early 1980s, although most Americans were generally aware that smoking was hazardous, many in the public, especially smokers, did not have sufficient information about the health risks of smoking to understand just how dangerous smoking was for them. …**So egregious were the actions of the tobacco industry that U.S. District Judge Gladys Kessler found the companies guilty of violations under the *Racketeer Influenced and Corrupt Organizations* (*RICO*) *Act*.** In her findings of fact, affirmed on appeal, Judge Kessler concluded the evidence revealed that the companies had participated in a **"scheme to defraud smokers and potential smokers in order to maximize their profits** by preserving and enhancing the market for cigarettes, to avoid costly liability judgments, to derail attempts to make smoking socially unacceptable, and to sustain the cigarette industry." (779)

[Tobacco control] advocacy efforts, loosely organized and networked at best, faced the formidable challenge of opposing the responses of the well-funded and highly centralized tobacco industry. In an analysis of **tobacco industry tactics**, the Advocacy Institute defined nine areas of activity: **intimidation, alliances, front groups, campaign funding, lobbying, legislative action, buying expertise, philanthropy, and advertising and public relations**. In its discussion of well over 100 instances in these areas, which were documented largely from media reports, the Advocacy Institute does not accuse the tobacco industry of illegal activity, but rather, of far-ranging and **systematic efforts to ensure the continued use of tobacco products**. (779)

Taken together, and backed by the **enormous resources of the industry**, efforts by the tobacco companies have had considerable impact in promoting tobacco use and slowing efforts to reduce or prevent it. (779)

For example, a ballot initiative that would have raised the excise tax on cigarettes sold in California was defeated by a small margin (50.3% to 49.7%); opponents, backed by the tobacco industry, had fewer donors but were far better funded[1]:

Figure 1. Funding Sources for California's Proposition 29



Source: Voter's Edge (http://votersedge.org/california/ballot-measures/2012/june/prop-29/funding#.VG4S9MlAd63)

The tobacco industry exercises tremendous* political influence*, thereby thwarting sound and effective tobacco controls.

The industry weakens otherwise meaningful public health regulation. For example, its influence protected its interest when the federal government enacted a requirement that cigarettes carry a health warning label. The warning's language failed to match the scientific evidence of the time, and the law explicitly prohibited complementary regulations for a period of years.

> In 1965, the *Federal Cigarette Labeling and Advertising Act of 1965* mandated the first Surgeon General's warning to appear on cigarette packages: "Caution: Cigarette Smoking May Be Hazardous to Your Health." However, at the same time it prohibited FTC from taking any new regulatory action to control cigarette advertising for 4 years. Contemporary observers explained that the tobacco industry had decided it was in their interest to accept the warning label in exchange for halting any regulatory efforts. However, subsequent analyses have shown how the **tobacco industry used its connections within government to assure a weak bill and a weak warning label**. **The wording of the label, "Caution: Cigarette Smoking May Be Hazardous to Your Health," contrasts sharply with the certainty of the 1964 report's conclusion on smoking and lung cancer.** (23-24)

This strategy of watering-down tobacco control policy permits the industry to appear willing to comply with regulation for the good of public health (and similarly permits sympathetic policymakers to do so), while ensuring no regulation will actually affect its ability to profit from its deadly products.
At times, the industry blocks public health regulation altogether. For example:

> Between 1985–2001, both [the Department of Defense] and the U.S. Congress attempted to increase commissary cigarette prices [on military bases], but **these efforts were largely thwarted by the tobacco industry**. (778)

The industry enjoys so much influence that its leaders have been emboldened to lie on the record and under oath about what they knew about their products.

> At a 1994 [Congressional] hearing, **seven tobacco company CEOs insisted that they believed nicotine was not addictive and not a cause of disease**. (32)

The tobacco industry has systematically used its vast wealth and other resources to manipulate public discourse about its deadly products.

The industry positioned itself to be indispensable to print news companies, thereby influencing the articles and stories published by those companies, including respected news magazines.

> **[T]he tobacco industry's power as a source of revenue for many print publications influenced the content of smoking and health media coverage**. After the broadcast advertising ban, cigarette advertising and marketing continued to grow, but shifted to print publications, outdoor billboards, sponsorship of sports, placement of brand implants in movies, and a number of other methods. According to *Advertising Age*, the five major tobacco companies spent $62 million on magazine advertising in 1970, the year before the ban, but by 1976 they were spending $152 million. Some publications became highly dependent on this revenue. An article in the *Columbia Journalism Review* noted a trend: **"In magazines that accept cigarette advertising, [the author] was unable to find a single article, in seven years of publication, that would have given readers any clear notion" of the nature and extent of the health effects of cigarette smoking, including news magazines like *Time* and *Newsweek*.** As late as 1983, a *Newsweek* 16-page special supplement on "personal health care" prepared with [the American Medical Association] failed to explicitly identify cigarette smoking as a major health hazard. The same issue carried 12 pages of cigarette advertisements worth about $1 million in revenue for the magazine. An analysis of magazine coverage over a 22-year period found that **a sample of major magazines reduced their coverage of smoking and health issues by 65% in the years after the broadcast advertising ban went into effect, and another study found that magazines which accepted an average amount of cigarette advertising were 38% less likely to carry stories on smoking and health than magazines that did not accept cigarette advertising**. (26)

The tobacco industry uses litigation *to delay sound regulation and avoid liability for its defective products.*

The industry challenges even sound tobacco controls to intimidate policymakers, delay policy implementation and extend the time in which they can operate outside of those controls. The Surgeon General's report identifies only a few examples:

In 2001, the Lorillard Tobacco Company (Lorillard) launched a series of attacks claiming that the truth campaign [an edgy and effective youth public education campaign] had violated the provisions of the Master Settlement Agreement (MSA), which prohibited the American Legacy Foundation (Legacy) from engaging in 'vilification' or 'personal attacks.'…[The Delaware Supreme Court unanimously rejected an effort by Lorillard to shut down Legacy or, at least, the truth campaign… . (App.14.3-3)

[S]uccessful litigation commenced by the tobacco industry around preventing the final graphic warning label rule from going into effect. On April 22, 2013 the Supreme Court of the United States declined to hear the appeal of the March 2012 ruling by the U.S. Court of Appeals for the Sixth Circuit. There is the ongoing possibility of litigation from the tobacco industry. (787)

This litigation (or threat of litigation) may come through front groups or allied trade groups (e.g. retailer or hospitality organizations), which the public and policymakers may find more credible or sympathetic. In New York alone, the industry—allying itself with retailer organizations—has (unsuccessfully) challenged reasonable New York City efforts to regulate the price of tobacco products and restrict the sales of certain products.[2]

The tobacco industry has gone to dramatic lengths to undermine *sound science to ensure continued profits.*

The lengths to which the industry goes to discredit negative research findings is unparalleled. The tobacco industry successfully deceived millions and cast doubt on reliable evidence of cigarette toxicity and addictiveness. For decades, tobacco companies conducted their own research and knew not only that nicotine was addictive, but that their products caused significant and adverse health effects. The criticism of sound research has often been filtered through front groups and third party allies.

Manufactured a Harmful Product

The American tobacco industry's strategies for dealing with scientific evidence documenting the harms of its products … originated during the 1950s. … In a now well-documented effort to counter this evidence and to minimize risk to the industry, the **executives of the major tobacco companies met** in December 1953 and, with the guidance of the advertising firm Hill & Knowlton, **devised a unified strategy that included the founding of an industry-funded research organization**, initially the Tobacco Industry Research Committee (TIRC) and later the Council for Tobacco Research, and the nationwide publication of the "Frank Statement," which publicly stated the industry's commitment to public health. Clarence Cook Little, a leading researcher and academician, was hired in 1954 as the first head of TIRC; he assumed a public position of skepticism with regard to the evidence on smoking and health, **seeking to create doubt about the harmful effects of smoking**. For decades, the industry followed the strategies set out in the early 1950s: **denying the harms of its products, discrediting the scientific evidence that showed these harms, funding research that was intended to divert attention from cigarettes, and marketing new products with implied lower risks than existing products**. (20)

The tobacco industry … [has **p]ublicly denied, distorted, and minimized the hazards of smoking for decades**. …[T]he evidence shows that the [tobacco industry] **knew for fifty years or more that cigarette smoking caused disease**, but repeatedly denied that smoking caused adverse health effects. (internal quotations omitted) (801)

A Frank Statement to Cigarette Smokers

RECENT REPORTS on experiments with mice have given wide publicity to a theory that cigarette smoking is in some way linked with lung cancer in human beings.

Although conducted by doctors of professional standing, these experiments are not regarded as conclusive in the field of cancer research. However, we do not believe that any serious medical research, even though its results are inconclusive should be disregarded or lightly dismissed.

At the same time, we feel it is in the public interest to call attention to the fact that eminent doctors and research scientists have publicly questioned the claimed significance of these experiments.

Distinguished authorities point out:

1. That medical research of recent years indicates many possible causes of lung cancer.

2. That there is no agreement among the authorities regarding what the cause is.

3. That there is no proof that cigarette smoking is one of the causes.

4. That statistics purporting to link cigarette smoking with the disease could apply with equal force to any one of many other aspects of modern life. Indeed the validity of the statistics themselves is questioned by numerous scientists.

We accept an interest in people's health as a basic responsibility, paramount to every other consideration in our business.

We believe the products we make are not injurious to health.

We always have and always will cooperate closely with those whose task it is to safeguard the public health.

For more than 300 years tobacco has given solace, relaxation, and enjoyment to mankind. At one time or another during those years critics have held it responsible for practically every disease of the human body. One by one these charges have been abandoned for lack of evidence.

Regardless of the record of the past, the fact that cigarette smoking today should even be suspected as a cause of a serious disease is a matter of deep concern to us.

Many people have asked us what we are doing to meet the public's concern aroused by the recent reports. Here is the answer:

1. We are pledging aid and assistance to the research effort into all phases of tobacco use and health. This joint financial aid will of course be in addition to what is already being contributed by individual companies.

2. For this purpose we are establishing a joint industry group consisting initially of the undersigned. This group will be known as TOBACCO INDUSTRY RESEARCH COMMITTEE.

3. In charge of the research activities of the Committee will be a scientist of unimpeachable integrity and national repute. In addition there will be an Advisory Board of scientists disinterested in the cigarette industry. A group of distinguished men from medicine, science, and education will be invited to serve on this Board. These scientists will advise the Committee on its research activities.

This statement is being issued because we believe the people are entitled to know where we stand on this matter and what we intend to do about it.

TOBACCO INDUSTRY RESEARCH COMMITTEE

5400 EMPIRE STATE BUILDING, NEW YORK 1, N. Y.

SPONSORS:

THE AMERICAN TOBACCO COMPANY, INC.
Paul M. Hahn, President

BENSON & HEDGES
Joseph F. Cullman, Jr., President

BRIGHT BELT WAREHOUSE ASSOCIATION
F. S. Royster, President

BROWN & WILLIAMSON TOBACCO CORPORATION
Timothy V. Hartnett, President

BURLEY AUCTION WAREHOUSE ASSOCIATION
Albert Clay, President

BURLEY TOBACCO GROWERS COOPERATIVE ASSOCIATION
John W. Jones, President

LORILLARD & BROTHER COMPANY, INC.
W. T. Reed, Jr., President

P. LORILLARD COMPANY
Herbert A. Kent, Chairman

MARYLAND TOBACCO GROWERS ASSOCIATION
Samuel C. Linton, General Manager

PHILIP MORRIS & CO., LTD., INC.
O. Parker McComas, President

R. J. REYNOLDS TOBACCO COMPANY
E. A. Darr, President

STEPHANO BROTHERS, INC.
C. S. Stephano, D'Sc., Director of Research

TOBACCO ASSOCIATES, INC.
(An organization of flue-cured tobacco growers)
J. R. Watson, President

UNITED STATES TOBACCO COMPANY
J. W. Peterson, President

Deceived about Addictive Qualities

Since the 1950s, [the major U.S. tobacco companies] have researched and **recognized, decades before the scientific community did, that nicotine is an addictive drug**, that cigarette manufacturers are in the drug business, and that cigarettes are drug delivery devices. …[F]or over 40 years, the [tobacco companies'] research had shown that the nicotine in tobacco causes cigarette smoking to be addictive. [These companies] not only publicly denied that smoking is addictive but also **withheld information about their research** from the American public, the government, and the public health community, including the United States Surgeon General. …[T]the evidence shows the [tobacco companies] acted this way **to maintain profits by keeping people smoking and attracting new consumers, to avoid liability, and to prevent regulation of the industry**. (internal quotations omitted) (801)

The finding [in the 1986 Surgeon General's Report] that nicotine was addicting countered the argument that people became smokers by their own free choice. Efforts to discredit the report continued long after its publication, even though **the industry's own documents show that it had long known that nicotine was addicting**. (31)

Undermined Evidence of Environmental Tobacco Smoke Hazard

[Tobacco industry] statements about secondhand smoke sought "to **deceive the public, distort the scientific record, avoid adverse findings by government agencies, and forestall indoor air restrictions**". [T]he evidence shows that the [tobacco companies] have long known that secondhand smoke, or environmental tobacco smoke, is hazardous to nonsmokers and that [tobacco companies] have understood how this information could affect the tobacco industry's profitability. [The evidence from U.S. v. Philip Morris demonstrates that the tobacco companies took steps], **after promising to support objective research on the issue, to undermine independent research efforts, to fund industry-friendly research, and to suppress and trivialize unfavorable research results**. (801-802)

The emerging evidence on exposure to secondhand smoke and disease, particularly lung cancer, sparked a vigorous response from the tobacco industry that is now well documented. The tobacco industry recognized the policy implications of evidence showing that exposure to secondhand smoke caused adverse effects among nonsmokers and **initiated strategies to undermine the research findings, seeking to create doubt about the credibility of evidence that would drive policy-making**. The first major study to link exposure to secondhand smoke to lung cancer…was the target of an **orchestrated campaign to undermine its findings**. The tactics included arranging critical letters to the editor of the *British Medical Journal*, which published the paper, commissioned research with the intent of obtaining findings that would point to bias in the study, and even newspaper advertisements discrediting the findings. Such strategies were directed at the wider body of evidence on secondhand smoke and health; the industry and its consultants raised methodologic problems… in order to sustain doubt about the findings. These same tactics and others were used to try and diminish the impact of the 1986 Surgeon General's report…[and] in an attempt to derail EPA's risk assessment of environmental tobacco smoke. (29)

[Tobacco companies] attempted to and, at times, did prevent/stop ongoing research, hide existing research, and destroy sensitive documents in order to protect their public positions on smoking and health, avoid or limit liability for smoking and health related claims in litigation, and prevent regulatory limitations on the cigarette industry. …

> [F]or over 50 years, the [tobacco companies] tried to protect themselves from litigation and regulation by (1) **suppressing and concealing scientific research**, (2) **destroying documents**, and (3) shielding other documents from public view by asserting that they were "privileged" and protected by law…. [The tobacco companies'] destruction of documents makes it impossible to know what materials once existed. (internal quotations omitted) (802)
>
> [In 1959,] a review by leading public health scientists assessed a range of potential criticisms of the research findings [that smoking causes disease] and concluded that the **evidence was overwhelming**: "if the findings had been made on a new agent, to which hundreds of millions of adults were not already addicted, and on one which did not support a large industry, skilled in the arts of mass persuasion, the evidence for the hazardous nature of the agent would generally be regarded as beyond dispute". (21)

The industry's organized efforts successfully deceived millions of consumers—at grave risk for disease and premature death caused by tobacco products—convincing them that the risks were exaggerated and unproven.

> Although antismoking publicity and news reports did have an impact on beliefs and behavior over time, there were also forces working against this trend. In particular, the tobacco industry's marketing efforts and **organized campaign to promote doubt around smoking and health** surely slowed the pace of change. A 1966 PHS survey found that more than 60% of smokers agreed that the cancer link was "not yet proved" because it was "only based on statistics". Additionally, well over one-half of all smokers believed that most people would not be convinced smoking was harmful until "the tobacco industry itself" admitted the fact. Even as public knowledge about the link between smoking and lung cancer became widespread during the 1970s and 1980s, a 1981 FTC review concluded that many Americans still had very limited knowledge of the nature and extent of the health risks or how those risks applied to their own behavior. (25)

Industry resources influence the outcome of scientific studies. For example, industry-funded studies supported the therapeutic use of cigarettes to treat psychiatric disorders, such as Alzheimer's and schizophrenia.

> Data from observational studies describing the protective effects of smoking on the risk of [specific conditions] are often cited in industry-sponsored and nonindustry-sponsored literature as evidence to support the therapeutic applications of nicotine. However, there is evidence that the **tobacco industry influenced many of these epidemiologic studies of smoking and psychiatric disorders**. For example, an analysis of publications on the relationship between smoking and Alzheimer's disease that controlled for authors' industry affiliation revealed that pooled [odds ratios] for studies without industry funding were neutral or indicated an increased risk with smoking, depending on study design, while **industry-affiliated studies indicated a reduced risk**. (124)
>
> [T]he industry sought to influence scientific attitudes regarding the role of smoking in schizophrenia. Tobacco industry documents indicate that **the industry funded research for the specific purpose of perpetuating the belief that smoking improves symptoms in schizophrenic patients, advocated for exceptions for smoking in hospitalized psychiatric patients**, and funded studies of medicinal uses of nicotine analogs to treat mental illnesses. (124)
>
> [A study] found that authors acknowledging tobacco industry funding were much less likely than nonindustry-funded authors to report a negative effect of nicotine on cognitive performance. Nonindustry-funded authors reported both positive and negative findings, while **industry-funded authors reported positive findings almost exclusively**. (124)

The tobacco industry orchestrated* marketing *campaigns specifically to deceive the public and entice them to use their deadly and addictive products.

Source: Richard Pollay Tobacco Advertising Collection at Roswell Park Cancer Institute, Buffalo, NY. (775)

Tobacco marketing has deliberately deceived the public about the health hazards of smoking for decades. Some marketing strategies have made explicit and fraudulent health claims (or claims of reduced harm).

Although physicians generally did not see a significant health threat for most smokers, there was growing concern over cigarette advertising during the 1930s and 1940s that made a wide array of **unfounded health claims**. In the highly competitive branded cigarette market, **prominent advertising campaigns included explicit health claims**: "Not a cough in a carload"; "we removed from the tobacco harmful corrosive acids (pungent irritants) present in cigarettes manufactured in the old fashioned way"; "Smoking Camels stimulates the natural flow of digestive fluids … increases alkalinity". Kool menthol cigarettes, characterized by the cooling effect of this additive, were offered to nose and throat specialists to hand out to their patients "suffering from colds and kindred disorders" (19)

The nature of cigarette advertising also changed, apparently in response to adverse publicity, to **obscure the extent of the danger**. During the 1970s, there was an increased emphasis on ads that featured claims about tar and nicotine content, **implying reduced exposures to cancer-causing agents**. Key words such as "light," "smooth," and "mild," were used to convey health-related messages. In the 1980s, these health messages became more subtle, relying on imagery of active, healthy models. (25-26)

[Tobacco companies] **falsely marketed and promoted low tar/light cigarettes as less harmful** than full flavor cigarettes in order to keep people smoking and **sustain corporate revenues**. … [S]ince the 1970s, [tobacco companies] have **misled consumers** into believing that so-called "low tar" and "light" cigarettes are healthier than other cigarettes and are an acceptable alternative to quitting. [The tobacco companies] do this even though **they have known for decades that light cigarettes offer no clear health benefit**. …[The tobacco companies] dramatically increased their sales by **exploiting consumers' belief that light cigarettes are less harmful, while claiming falsely that their marketing is based only on smokers' preference for a lighter taste**. [A federal court recently found] that the [tobacco companies] are **continuing to make these false and misleading claims in order to reassure smokers and dissuade them from quitting**. (internal quotations omitted) (801)

The Court of Appeals affirmed [U.S. District] Judge Kessler's determinations that the cigarette manufacturers engaged in **deliberate deception, with "specific intent" to defraud consumers**. In rejecting the companies' claims that their **deliberately false and misleading statements** were protected First Amendment "free speech," the D.C. Circuit stressed that the companies "**knew of their falsity** at the time and made the statements with the **intent to deceive**," and observed, "we are not dealing with accidental falsehoods, or sincere attempts to persuade; [tobacco industry d]efendants' liability rests on **deceits perpetrated with knowledge of their falsity**". (802)

There is no reason to believe the industry's strategies have changed.
Based on a federal judge's findings of fact:

[T]he evidence [presented in the 2006 case of U.S. v. Philip Morris] shows that the [companies] **continue to deny** the extent to which secondhand smoke is hazardous to nonsmokers. (802)

Based on [the U.S. District Court's finding that the tobacco companies violated RICO], Judge Kessler determined that they were **reasonably likely to continue engaging in fraud and deceit…**. (802)

Based on the **cigarette companies' demonstrated "proclivity for unlawful conduct**," the D.C. Circuit substantially affirmed Judge Kessler's remedies. (802)

The tobacco industry has strategically* engineered *cigarettes and other tobacco products to be more appealing, addictive and dangerous.

Cigarettes are highly engineered products.

Although smokers may perceive cigarettes as very simple devices: chopped-up tobacco rolled in paper, perhaps with a filter attached to the end, the reality, however, is that cigarettes are highly engineered products. The design features of cigarettes can have significant effects on the composition of the tobacco smoke and perhaps its toxicity. Over time, changes to cigarettes have become progressively more extensive and more complex, further complicating the efforts of researchers to understand their health implications (153)

Previous Surgeon General's reports have tracked the evolution of cigarettes into the current highly engineered, addictive, and deadly products containing thousands of chemicals that are themselves harmful. The burning of tobacco produces the complex chemical mixture of over 7,000 compounds that cause a wide range of diseases and premature deaths as a result. (869)

[Tobacco companies] have designed their cigarettes to **precisely control nicotine delivery levels** and provide doses of nicotine sufficient to **create and sustain addiction**. … [The tobacco companies] control the nicotine levels in cigarettes to ensure that smokers become addicted and stay addicted. …[**A]lthough the [tobacco companies] deny publicly that they manipulate or control the nicotine levels, the facts prove otherwise**. (internal quotations omitted) (801)

The evidence is sufficient to conclude that the **increased risk** of adenocarcinoma of the lung in smokers **results from changes in the design and composition of cigarettes** since the 1950s. (8-9)

Evidence suggests that changes in the composition and design of the cigarette itself may have had some impact on the relative risk of lung cancer, as well as on the shift in the types of lung cancer occurring in the contemporary cohorts of smokers (6)

It has been stated that "**The cigarette is also a defective product, meaning not just dangerous but *unreasonably* dangerous, killing half its long-term users. And addictive by design.**" (15)

[T]oday's cigarette smokers—both men and women—have a **much higher risk** for lung cancer and chronic obstructive pulmonary disease (COPD) than smokers in 1964, **despite smoking fewer cigarettes**. (ES-1)

Cigarettes are engineered and marketed to create and sustain maximum addiction and appeal.

[C]igarettes have been researched, designed, and manufactured to **increase the likelihood that initiation will lead to dependence and difficulty achieving cessation** due to contents and emissions in addition to nicotine (e.g., acetaldehyde, ammonia compounds, and menthol); design features that may increase free-base nicotine and produce larger puffs (filter-tip ventilation); and other factors that reduce the concerns for smokers and increase the attractiveness of the products. (112)

Since the mid-1990s' release of the tobacco industry documents, it has been increasingly evident how **extensive were the research, manufacturing, and marketing efforts by the industry to make products more acceptable and addictive**. These examples illustrate that the risk, severity, and persistence of addiction to tobacco, like addiction to other substances, are influenced by many factors beyond the pharmacology of the addicting drug. These include social factors; perceptions of harm, cost, and access; and the formulation of the drug itself. (784)

Tobacco has been grown and used in the Americas for many millennia, but widespread use of highly addictive cigarettes is relatively recent, beginning at the end of the nineteenth century. (845)

Substantial longitudinal research has shown that smoking typically begins with experimental use of cigarettes and that the transition to regular smoking can occur relatively quickly, with the smoking of as few as 100 cigarettes. (113)

The 2012 Surgeon General's report makes clear that addiction can begin in people who begin experimenting with tobacco use during their teenage years. Although the phenotype of addiction is not so well defined as with adults, symptoms of withdrawal occur among youth who become regular smokers. (113)

Similarly, many changes in tobacco product form and marketing have been documented as **efforts by the tobacco industry** to contribute to tobacco use and addiction by **fostering initiation among young people**; making products **easier and more acceptable** to use; making and **marketing** products so as to address health concerns; and making and marketing products to **perpetuate addiction** through the use of alternate products, when smoking is not allowed or is socially unacceptable. (784)

Tobacco products are **engineered and marketed** to attract specific (and often vulnerable) populations.

Products intended to encourage initiation by youth tend to have characterizing flavors and lower nicotine levels, while those intended for established users have higher nicotine content and fewer characterizing flavors.

Characteristic	Target Consumer
Flavored, lower nicotine levels	Youth
High nicotine levels	Established user (most of whom wish to quit)
Cigarette filters	Established smokers concerned about health risks
Menthol	Youth, young adult, female, African American

> [C]igarettes were designed to make smoke more easily inhalable and to provide low-tar and nicotine yields in smoking machine tests. Smokeless tobacco products were designed with nicotine delivery and flavor characteristics targeted to certain populations, such as low-dose nicotine delivery fruit-flavored products for initiation by youth and higher dosage products targeted to tolerant longer term users. Similarly, FDA's TPSAC found that menthol in cigarettes was a design feature that produced physiological effects, including sensory effects contributing to tobacco use; and marketing and product branding of menthol and its effects also contributed to initiation and persistence of cigarette smoking. (782)

Tobacco companies' deceptive marketing is all the more offensive because of the identity of their target audience.

Industry and youth

According to the 2012 Surgeon General's Report on smoking, cigarette marketing and promotion—particularly marketing at the point of sale—*cause* smoking by youth (largely among youth too young to legally purchase tobacco products). The industry knows this and yet its business model requires that it prioritize this type of marketing in an effort to recruit "replacement smokers" to keep their business alive and profitable. They know that nearly 90% of adult regular smokers start by the age of 18 and that virtually no one begins to smoke after the age of 26.

> The evidence is clear and convincing – and beyond any reasonable doubt **– that [tobacco companies] have marketed to young people twenty-one and under while consistently, publicly, and falsely, denying they do so**. …[The tobacco companies] **tracked youth behavior and used the information to create highly sophisticated marketing campaigns to get young people to start smoking** and continue smoking. [The industry] sought to remain profitable by **bringing new, young smokers into the market to replace those who die or quit**. (internal quotations omitted) (801)

> The tobacco industry continues to position itself to sustain its sales by **recruiting youth** and young adults and by maintaining current smokers as consumers of all their nicotine-containing products including cigarettes. (14)
>
> Through its advertising and promotional campaigns, the tobacco industry markets heavily to its youngest **legal** target: young adults (709)
> As a result of tobacco marketing and other influences, **more than 3,200 children younger than the age of 18 smoke their first cigarette every day**. Another 2,100 youth and young adults who are occasional smokers become daily smokers. (Consumer Guide 3)
>
> The *Tobacco Control Act* incorporates as congressional findings of fact [U.S. District] Judge Kessler's determinations that "**the major United States cigarette companies continue to target and market to youth**," that the companies sought to "encourage youth to start smoking subsequent to the signing of the Master Settlement Agreement in 1998." (800)

[T]he root cause of the smoking epidemic is also evident: **the tobacco industry aggressively markets and promotes lethal and addictive products, and continues to recruit youth** and young adults as new consumers of these products. …[A federal court found that] the **tobacco industry defendants violated the *Racketeer Influenced and Corrupt Organizations Act* by lying, misrepresenting, and deceiving the public "including smokers and the young people they avidly sought as 'replacement smokers,' about the devastating health effects of smoking and environmental tobacco smoke**". (871)

[T]he 2012 Surgeon General's report concluded that "**the evidence is sufficient to conclude that there is a causal relationship between advertising and promotional efforts of the tobacco companies and the initiation and progression of tobacco use among young people**". (797)

The evidence is sufficient to conclude that advertising and promotional activities by the tobacco companies **cause the onset and continuation of smoking among adolescents** and young adults. (827)

According to FTC, in 2010 more than $8 billion was spent on cigarette advertising and promotion in the United States. This sum spent on advertising and promotions threatens public health, as it increases overall smoking and **encourages youth to begin to smoke**. The tobacco industry and consultant researchers contend that there is no definitive research showing that advertising increases smoking; however, this claim is countered by longitudinal research and strong empirical evidence, including the tobacco industry's own internal documents and trial testimony, that **there is a consistent dose-response relationship between the marketing and promotional efforts by tobacco companies and the initiation and progression of tobacco use among young people**. (796-797)

Industry and ethnic, racial and sexual minorities, and low socioeconomic communities

Some of the highest smoking prevalence rates have been observed among persons of lower socioeconomic status, sexual minorities (including individuals who are gay, lesbian, bisexual and transgender, and individuals with same-sex relationships and/or attraction), high school dropouts…as well as among vulnerable populations with complex comorbid medical illness (e.g., HIV/AIDS and cardiovascular disease), mental illness and alcohol and substance abuse disorders). (761)

At present, the tobacco retail environment serves unique roles in industry marketing and promotional activities. …[T]he presence of heavy cigarette advertising in convenience stores, **especially in predominately ethnic and low-income neighborhoods**, increases the likelihood of exposing youth to prosmoking messages, which can increase initiation rates among those exposed, particularly if stores are near schools. Therefore, based upon the findings in the 2012 report, **local policies and approaches to reduce point-of-purchase advertising and promotions have increased**. (797)

Menthol brands entered the market in the 1930s and their use greatly expanded in the 1950s when **aggressive marketing to African Americans** began. It has been noted that the widespread marketing of menthol cigarette brands in Black communities covered "…literally every aspect of life, from Black-owned publications and jazz concerts through civil rights groups, to massive billboards throughout the Black community" (782)

The manner in which the aggressive marketing of menthol cigarettes within Black communities resulted in persisting high rates of use of these brands among this group has been reviewed. More recent analyses of marketing campaigns in racial/ethnic communities have shown similar aggressive patterns of marketing of menthol cigarettes have continued. (782-783)

Industry and the military

[T]he males who were involved in World War II, or who were in adolescence during this era, initiated smoking at the highest rates and had the highest birth cohort prevalence of current smoking as young men. (778)

Tobacco use is still prevalent in the military, despite the official [Department of Defense] policy of strongly discouraging tobacco use, including prolonged and efficacious total tobacco bans during training. However, the tobacco industry continues to reach this vulnerable military population by such methods as the placement of a coupon inside the cigarette carton when external coupons and/or promotions were prohibited. Additionally, the industry has sent smokeless tobacco to Marines in Iraq, while maintaining that it was not a violation of the policy against distribution of free tobacco product samples, because they "responded to direct requests from troops". Further, in response to tobacco advertising regulations, the tobacco industry has turned to promotional opportunities in adult-only venues such as bars and pubs, particularly those near military bases as stated in one marketing report, "...it seems the venues located in close proximity to the bases attract a large crowd of demographically desirable consumers". (778)

[T]here are… active tobacco company influences that aggressively campaign and target the military. (App.14.1-6)

A few examples will give a true sense of the military-targeted tobacco marketing: (1) Industry members believe 'there is no other market in the country that has the sales potential of the military' and 'the plums are here to be plucked'; (2) Phillip [sic] Morris' advertising firm, Leo Burnette, reported that the world military market was a 'force to be reckoned with' since its size could be compared to the second largest U.S. city, it had a large concentration of young adult males, and was an 'economic giant.'…'One half million military personnel filter back into the civilian market every year, product preferences and all…And that's just one reason why the military market… is an important market'; and (3) As American troops were deployed to Saudi Arabia in August 1990, Philip Morris sent 10,000 cartons of Marlboro cigarettes via the 82nd Airborne Division from Pope Air Force Base in North Carolina. An internal document added, 'We will be everywhere the soldier is…'" (App. 14.1-5)

[A] recent investigation of pricing differences between 145 matched Walmart stores and military exchanges found that the average savings at an exchange was 25.4%. (App. 14.1-3)

In recent years, the tobacco industry has increasingly focused on targeted marketing in commercial magazines that are attractive to the military (e.g., Air Force Times). (App. 14.1-5)

Cigarettes are highly engineered products: filters

The addition of filters to cigarettes reduced measurable tar in tests conducted by the Federal Trade Commission, but may have actually *increased* health harms caused by cigarettes.

Since the 1950s, cigarettes have undergone changes in their design and composition. The most prominent changes have been the addition of filters and **the use of ventilation holes in the filters to lower machine-measured tar and nicotine yields**. [There was a] rapid rise in the use of filtered cigarettes that followed the heavy marketing of such cigarettes in the mid-1950s. The marketing effort promised a lower risk product to smokers who had become concerned about the disease risks of smoking. (152)

The evidence is not sufficient to specify which design changes are responsible for the increased risk of adenocarcinoma, but **there is suggestive evidence that ventilated filters and increased levels of tobacco-specific nitrosamines have played a role**. (8-9)

The principal mechanism underlying the lower yields of machine-measured tar was the increase in the number and the size of ventilation holes in the filter, thereby diluting the smoke entering the machine. Although these changes reduced tar delivery as measured by the U.S. Federal Trade Commission's (FTC's) protocol, which did not reflect how smokers actually smoke; they did not reduce the risks of disease and premature mortality in smokers. (153)

Cigarettes are highly engineered products: menthol cigarettes

The addition of menthol to cigarettes promotes initiation, increases the likelihood of addiction in youth smokers and makes cessation more difficult.

Menthol … has cooling, analgesic, and irritative properties, reflecting its interactions with specific neuronal biological receptors that can modulate pain and communicate to areas of the brain concerned with taste and other sensations. (782)

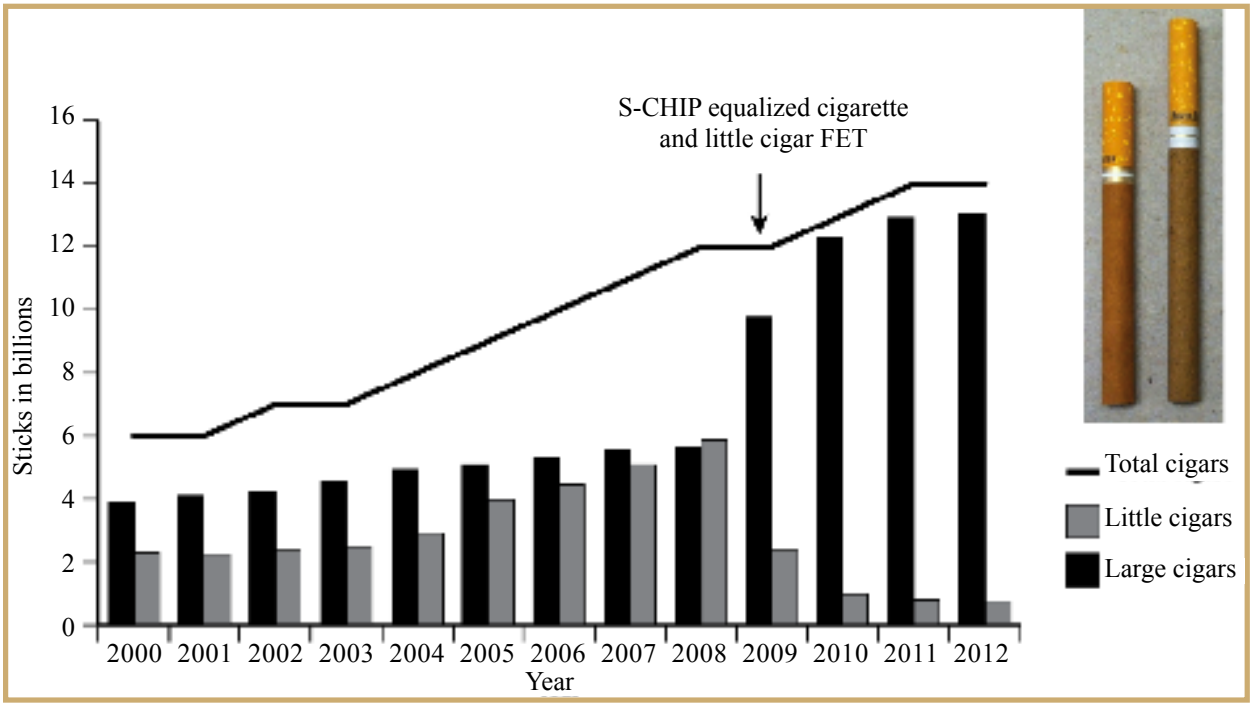
At present, menthol is a "characterizing flavor" for about 30% of cigarettes in the United States and it is present in most cigarettes at concentrations lower than in those labeled as menthol cigarettes. **Beyond being the predominant cigarette product smoked by African Americans, menthol cigarettes are popular among adolescents.** In analyses of nationally representative survey data from 2004 to 2010, youth and young adults were heavy consumers of mentholated cigarettes, with menthol use particularly associated with being younger, female, and of non-White race/ethnicity. Further, the survey data indicated that use of mentholated cigarettes has either remained constant or increased from 2004–2010 in youth and young adults while rates of use of nonmenthol cigarettes has been declining. Based upon these data, the authors suggested that **progress in reducing youth smoking rates in recent years likely has been attenuated by the sale and marketing of mentholated cigarettes**, including brands such as Camel Menthol and Marlboro Menthol. (783)

Cigars and other combustible products have evolved to undermine pricing regulations on cigarettes making them more attractive to targeted consumer groups, including youth, young adults and women.

Historically, cigar smoking in the United States has been a behavior of older men, but the **industry's increased marketing of cigars** during the 1990s to **targeted groups [such as youth, young adults, and women]** reversed the low rates of use among adolescents. Correspondingly, the rise in the prevalence of cigar use during the mid-1990s was not limited to adults. Instead, as documented by numerous local, state, and national surveys, cigar use and experimentation was widespread among both male and female adolescents. (734-735)

In addition, the industry manipulated the weight of some small cigars by adding a few grams of filler to make them qualify as large cigars, thus avoiding the tax increase. This change in classification resulted in a dramatic, immediate increase in large cigar use over a 2-month period. The industry also began repackaging and marketing pipe tobacco to be used for roll-your-own cigarette production. Evidence indicates that despite continued decreases in cigarette consumption in the United States, consumption of re-engineered pipe tobacco and large cigars has increased substantially since the federal tobacco excise tax was increased in 2009. (789-791)

Figure 3. Increase in Cigar Use after Industry Manipulated Product to Avoid Tax and More Widely Marketed



(707) Note: A "little cigar" is defined in the *Federal Cigarette Labeling and Advertising Act of 1965* as "any roll of tobacco wrapped in leaf tobacco or any substance containing tobacco (other than any roll of tobacco which is a cigarette within the meaning of subsection (1)) and as to which one thousand units weigh not more than three pounds." **FET** = federal excise tax; **S-CHIP** = State Children's Health Insurance Program. (707)

Other tobacco products are also engineered for maximum addiction.

As discussed by [the World Health Organization (WHO)], tobacco products vary widely in form, content, and emissions, but virtually all types are primarily represented by products that are **designed and manufactured to be addictive.** (782)

Emerging and evolving products reduce cessation and encourage polytobacco product use. Specifically, the industry promotes combustible products when smoking is permitted, and noncombustible products for circumstances in which smoking is prohibited.

[M]ore people are using multiple tobacco products, particularly youth and young adults. We need to monitor patterns of use of an increasingly wide array of tobacco products across all of the diverse segments of our society, particularly because the **tobacco industry continues to introduce and market new products that establish and maintain nicotine addiction**. (i)

[T]he use of multiple tobacco products is increasingly common, especially among young smokers. Concerns remain that use of these new products may increase initiation rates among youth and young adults, delay quitting, and prolong the smoking epidemic. (871)

Polytobacco use increased as educational level decreased …[and] polytobacco use among those below the poverty level (7.0%) was almost twice that of those at or above the poverty level (4.1%). (741)

Factors found to contribute to the continued growth of moist snuff use include increased tobacco company expenditures to promote moist snuff use, the initiation of snuff use among cigarette smokers (current or former) in the face of increasing cigarette prices and smoking bans, as well as the use of targeted marketing. Indeed, **advertising for some moist snuff products, often cobranded with cigarette names, has consistently included messages aimed explicitly at smokers and has positioned the products as modern and acceptable tobacco alternatives to use in places where smoking is banned or otherwise inconvenient**. (706)

While much remains unknown about the health effects of electronic nicotine delivery devices (e.g., electronic cigarettes), the fact that the major tobacco manufacturers are planning to market their own devices should cause great concern. Given the history of industry behavior, the design of these products and the manner in which they are marketed should be considered.

[Data from 2011-2012] suggested a doubling of electronic cigarette use among U.S. middle and high school students. (742-743)

[A]ll available data show rapid increases [of the use of electronic cigarettes] in recent years…. Ever use of electronic cigarettes also nearly doubled among all adults during 2010–2011…. (750)

In 2012, Lorillard acquired Blu Electronic Cigarettes, the manufacturer of Blu electronic cigarettes. In 2013, RJR announced that it will introduce VUSE electronic cigarettes and Altria announced that it will introduce MarkTen electronic cigarettes, thus, **all three major cigarette manufacturers plan to have electronic cigarettes on the market**. (780)

Given the level of evidence linking tobacco product use to ill health, all products containing tobacco and nicotine should be assumed to be both harmful and addictive, although the risk from the use of tobacco products depends not only on the type of product but also on how they are used (i.e., the actual doses of toxins that are taken in, and whether the product is used in addition to other products, promotes initiation of tobacco use, or delays smoking cessation). (780)

For example, ENDS have grown from a category of novelty products in 2005 to an extensively marketed and increasingly accessible category, with awareness of ENDS doubling … in 2010 and ever use of ENDS more than quadrupling from 2009 (0.6%) to 2010 (2.7%). Studies and assessments by FDA and independent scientists have demonstrated enormous variability in design, operation, and contents and emissions of carcinogens, other toxicants, and nicotine from ENDS. The marketing claims for ENDS also vary widely and have included claims of safety, use for smoking cessation, and statements that they are exempt from clean air policies that restrict smoking. (780)

Fortunately, now that the industry's deceitful tactics are better understood, its influence is diminishing. While the industry still opposes attempts to regulate its products, momentum is building to engage in "end game" strategies and eliminate the tobacco epidemic.

As scientific knowledge about the disease effects of smoking has advanced, and as research on tobacco industry documents and litigation have uncovered the deceptive and covert activities of tobacco companies, attitudes toward tobacco use and smoking in public places have changed from accepting to increasingly unfavorable. (773)

Litigation and investigation have yielded a better understanding of industry tactics: specifically, information about product design, deceptive marketing, pervasive use of the media, and dramatic lengths to control the social and political context of its products.

The tide began to change for the industry in the 1990s. The industry lost credibility with the public:

At a 1994 hearing, seven tobacco company CEOs insisted that they believed nicotine was not addictive and not a cause of disease. Photographs of the group holding up their right hands and being sworn in at the hearing, while denying what most members of the public knew to be true about cigarettes, turned them into objects of ridicule and further diminished the public's view of the tobacco industry. (800)

Evidence compiled by FTC and researchers demonstrated that the RJ Reynolds' Joe Camel marketing campaign had a measurable impact on smokers below the legal age and was accompanied by an increase in smoking initiation among youth. During this period, tobacco companies lost credibility in the eyes of the public. A Harris poll taken in March 1997 found that 92% of the respondents believed "tobacco companies know it causes cancer even if they do not admit it" and 80% believed that "some tobacco companies market their products deliberately to young people". (800)

There was one major development [in tobacco-related litigation] with *Cipollone v. Liggett Group, Inc.*, a personal injury case filed in 1983 on behalf of a New Jersey smoker and lung cancer victim. The plaintiffs gained access to some internal tobacco company documents supporting claims that **the industry had conspired to withhold information about harm from the public**. But, it was during the 1990s that far more complete access was gained to the industry's internal documents. (32)

> Opinions of the tobacco industry have fallen so low that it is now consistently ranked among the most distrusted of industries. (33)

Industry-funded research became unacceptable:

> [The tobacco industry] had also recruited researchers as consultants, who were key in its doubt-creating initiatives. Engagement with the industry became increasingly unacceptable for researchers whose reputations were tarnished by their industry activities. At the same time, concerns about potential conflicts of interest among scientists increased, and disclosure of consulting activities to universities became the norm, making it more difficult for researchers to maintain secret ties to the tobacco industry. (800)
>
> The tobacco industry had long funded researchers through the Council for Tobacco Research and later through the Center for Indoor Air Research. Such funding became increasingly unacceptable, and universities began to implement policies that prohibited receipt of funding from the tobacco industry. Engagement with the industry became increasingly unacceptable for researchers whose reputations were tarnished by their industry activities. (32-33)
>
> During the 1990s, a number of tobacco control researchers and organizations began to speak out against tobacco industry funding of research at academic institutions. Some academic medical journals instituted policies refusing to accept papers for review if the research had been funded by the tobacco industry. In 1994, a number of academic medical centers, including Brigham and Women's Hospital, Massachusetts General Hospital, MD Anderson Cancer Center, Roswell Park Cancer Institute, and others, adopted policies barring their faculty and staff from accepting tobacco industry support. (800)

The industry lost some (though certainly not all) of its influence over policy debates:

> Momentum from the states' lawsuits [in the 1990s to recover Medicaid expenses paid to care for sick smokers] turned the political tide against the tobacco industry in the mid-1990s, and their influence in Congress weakened. Additionally, the characteristics of legislative debates on tobacco control measures at the state level changed from its prior focus (on the sufficiency of scientific evidence of health effects during the 1970s and early 1980s) to the impact of tobacco industry activities and marketing on children. (32)

Most recently, the major U.S. tobacco companies were found guilty of violating the Racketeer Influenced and Corrupt Organizations Act (RICO), a statute often reserved for prosecuting organized crime:

> In the [Department of Justice] litigation, the industry was found guilty of violating civil racketeering laws and **lying to the public about the dangers of tobacco and its marketing to children**. The opinion by Judge Gladys Kessler focused on the representation of cigarettes with reduced machine yields of tar and nicotine as conveying lower risks and the industry's denial of the health effects of exposure to secondhand smoke. (800)
>
> Judge Kessler found the tobacco industry liable for perpetrating seven fraudulent schemes. The findings of this case have had a profound and continuing impact on public opinion and public policy. (800)
>
> Judge Kessler found that "the industry had marketed and sold their lethal products with zeal, with deception, with a single-minded focus on their financial success, and without regard for the human tragedy or social costs that success exacted".

The tobacco industry is the only legal industry to have been pursued and convicted under federal racketeering statutes. (33)

The specific remedies [imposed by U.S. District Judge Kessler] included prohibiting [tobacco manufacturers] from using brand descriptors (such as light, low-tar, mild, ultra light, and natural), which portray a healthier cigarette; requiring them to issue public "corrective statements" on the health consequences of smoking, cigarette addiction, industry manipulation of cigarettes as nicotine delivery devices, and the hazards of light and low-tar cigarettes; extending the defendants' obligation to maintain the Minnesota depository and their online document web/sites for tobacco documents for 15 additional years; and permanently enjoining (i.e., prohibiting) the defendants from "making, or causing to be made in any way, any material, false, misleading, or deceptive statement or representation. . . that is disseminated to the United States public and that misrepresents or suppresses information concerning cigarettes". On May 22, 2009, the D.C. Circuit upheld Judge Kessler's findings of fact, her determination of liability, and the majority of the remedies she ordered, and on June 28, 2010, the Supreme Court declined to accept review of the case, exhausting the cigarette companies' appeals. (802)

The court imposed several conditions to remedy the fraud perpetrated by the industry. The remedies include the publication of corrective statements by the industry, including the following two statements:

A Federal Court has ruled that the Defendant tobacco companies deliberately deceived the American public about the addictiveness of smoking and nicotine, and has ordered those companies to make this statement. Here is the truth:

- Smoking is highly addictive. Nicotine is the addictive drug in tobacco.
- Cigarette companies intentionally designed cigarettes with enough nicotine to create and sustain addiction.
- It's not easy to quit.
- When you smoke, the nicotine actually changes the brain—that's why quitting is so hard.

A Federal Court has ruled that the Defendant tobacco companies deliberately deceived the American public about designing cigarettes to enhance the delivery of nicotine, and has ordered those companies to make this statement. Here is the truth:

- Defendant tobacco companies intentionally designed cigarettes to make them more addictive.
- Cigarette companies control the impact and delivery of nicotine in many ways, including designing filters and selecting cigarette paper to maximize the ingestion of nicotine, adding ammonia to make the cigarette taste less harsh, and controlling the physical and chemical make-up of the tobacco blend. (803)

Section III.

ADVANCING TOBACCO CONTROL: ENDING THE TOBACCO EPIDEMIC

We know what policies reduce tobacco use. Moreover, research has provided evidence of promising "next generation" policies with the potential to accelerate tobacco control progress and end the tobacco epidemic. Intensified and sustained implementation of what works—fully-funded comprehensive tobacco control programs that impose meaningful taxes on tobacco products, prohibit smoking, and make cessation services accessible—will reduce tobacco use and improve public health. Implementation of innovative policies at the state and local level—such as those that reduce exposure to point of sale tobacco product marketing, reduce tobacco industry price manipulation, and restrict the sale of tobacco products—will help us end the tobacco epidemic.

Advancing Tobacco Control: Ending the Tobacco Epidemic

The tobacco control toolbox contains many policies that are proven effective in reducing both tobacco use and exposure to tobacco smoke. We know what strategies work in tobacco control, we need to do a better job of consistently funding and implementing them.

In 2000, Surgeon General Dr. David Satcher stated the challenge we face, namely, "**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**". (858)

Evidence-based tobacco control interventions that are effective continue to be underutilized and implemented at far below funding levels recommended by the Centers for Disease Control and Prevention. Implementing tobacco control policies and programs … on a sustained basis at high intensity would accelerate the decline of tobacco use in youth and adults, and also accelerate progress toward the goal of ending the tobacco epidemic. (858)

The scientific findings of the 2012 Surgeon General's report show that there are evidence-based strategies that can rapidly drop initiation and prevalence rates of smoking among youth to single digits. To reach this target, these strategies need to be fully implemented and sustained with sufficient intensity and duration. Without such increased and sustained action, 5.6 million youth younger than 18 years of age in this country today are projected to die prematurely from a smoking-related illness. (15)

For example, despite strong evidence of the efficacy of comprehensive state-wide tobacco control programs in reducing the initiation, prevalence, and intensity of smoking among youth and young adults, in 2010 **the states were appropriating only 2.4% of their tobacco revenues for tobacco control**. Further, it has been noted that reaching CDC's recommended funding level would have required an additional 13% of tobacco revenues, or $3.1 billion of the $24 billion collected from the industry, yet the annual total state funding level has declined from the high in fiscal year 2003 and **has declined even more sharply in several states where the efficacy of the programs was being demonstrated**. (852)

Since the 1964 Surgeon General's report, comprehensive tobacco control programs and policies have been proven effective for controlling tobacco use. Further gains can be made with the full, forceful, and sustained use of these measures. (4)

[In the foreword to the 1979 Surgeon General's Report on Smoking and Health, Secretary of Health, Education and Welfare] Califano wrote: "But why, the reader may nevertheless ask, should government involve itself in an effort to broadcast these facts and to discourage

cigarette smoking? … Why, indeed? For one reason, because the consequences are not simply personal and private. Those consequences, economic and medical, affect not only the smoker, but every taxpayer" (27)

The evidence is clear—we know what works. . . . Health care policies following from [recent federal legislation] should increase screening for tobacco use and offering cessation counseling in health care settings. [Research suggests] that the rate of decline in youth and adult levels of smoking and tobacco use could be accelerated if the most effective tobacco control interventions were more fully implemented simultaneously and this implementation was sustained.

However, the current levels of implementation of these key strategies are far below the most effective levels. (857)

Public health efforts to control tobacco use have been bolstered by policies at the national, state, and local levels. (788)

Fifty years after the release of the first Surgeon General's report warning of the health hazards of smoking, we have learned how to end the tobacco epidemic. (Exec Summ. Message from Kathleen Sebelius)

The past 50 years has witnessed a dramatic shift in attitudes among Americans toward tobacco products and the use of tobacco. This shift, from tobacco products being a widely accepted element of daily life to an addiction viewed unfavorably, has been driven by public health interventions and policies that discourage tobacco use and by the steps taken to regulate tobacco products and protect the population. We now have multiple examples of successful interventions, policies, and regulatory approaches, and these should guide future efforts to reduce tobacco use among youth and adults. Although there has been significant progress, much remains to be done in applying what is known to control tobacco use and in adapting these approaches to the new challenges for tobacco control as the industry diversifies its product lines. (826)

In addition to strategies associated with statewide and community-based policies and programs, essential components of a comprehensive tobacco control program also include disparity elimination initiatives and interventions specifically aimed at influencing youth. Because some populations experience a disproportionate health and economic burden from tobacco use, a focus on eliminating such tobacco-related disparities is necessary. To ultimately eliminate tobacco-related disparities, equity in tobacco prevention and control must be achieved by removing avoidable structural and social barriers and equally implementing tobacco control programs and policies. (812)

There are important lessons to be learned from other successes in public health. In confronting worldwide epidemics caused by smallpox and polio, the eradication of the diseases was the clear objective. From this single-minded focus, the best strategies and actions based on public health science and practice were applied, evaluated, refined, and sustained for decades. The results are now evident: smallpox was eradicated decades ago and polio is on the verge of elimination. The nation should firmly commit to this goal of creating a society free of tobacco-related death and disease by engaging all sectors of society to an equally single-minded focus. (875)

There is extensive knowledge about what needs to be done—not achieving greater progress results in part from not fully implementing existing knowledge about what works, and in part from the continued efforts of the tobacco industry to promote and market cigarettes and other products. (869)

What works: Comprehensive state and community tobacco control programs that include price increases, smoke-free air policies, access to cessation services, and mass media anti-tobacco campaigns.

Comprehensive tobacco control programs are funded as ongoing public health efforts to implement and coordinate evidence-based **population-level interventions**, (1) prevent initiation of tobacco among youth and young adults, (2) promote quitting among adults and youth (3) eliminate exposure to secondhand smoke (4) identify and eliminate tobacco-related disparities among population groups. (804)

We have many tools that we know work. A comprehensive public policy approach emphasizing **mass media campaigns** to encourage prevention and quit attempts, smokefree policies, **restrictions on youth access** to tobacco products, and **price increases** can collectively drive further meaningful reductions in tobacco use. Furthermore, we can accelerate progress through full commitment to clinical and public health advances; including the widespread use of telephone **quit lines and science-based counseling and medications** for tobacco users. (Exec. Summ. Message from Howard Koh)

Evidence shows that large tax and, hence, **price increases** will decrease tobacco use each time they are implemented. But legislative willingness to substantially increase taxes would need to increase dramatically. Similarly, **mass media campaigns** can be very effective; however, to produce large declines in the prevalence of adult smoking at the national level, these campaigns need to be **implemented on a sustained basis with updated content**. The impact of smokefree policies, and other factors **affecting social norms**, has increased dramatically during the last 50 years. However, since fewer states have implemented new comprehensive smokefree policies in the last few years, the pace of social norm change may have slowed. The pace of social norm change could be slowed by the recent increase in the level of tobacco depictions in top-grossing U.S. movies and the aggressive marketing and promotions for electronic cigarette brands. (852)

During the decades that followed [the first Surgeon General's Report on Smoking and Health in 1964],…a number of local, state, and federal laws and policies addressed tobacco product marketing and advertising, labeling and packaging, youth access, and exposure to secondhand smoke. **Social norms** that had made smoking acceptable everywhere began to change as a grassroots movement aimed at protecting nonsmokers emerged. Surgeon General's reports on the impact of tobacco use on specific populations, the changing cigarette, nicotine addiction, specific smoking-related diseases, and secondhand smoke gave impetus to a steady movement away from smoking as an acceptable social norm. (5)

Advocacy at the local grassroots level played a critical role as nonsmokers demanded smoke-free environments. The need for using a battery of tobacco control measures was recognized and trials were carried out at the community level to assess the efficacy of combined approaches and their effectiveness in practice. (31)

States that have made larger investments in comprehensive tobacco control programs have seen larger declines in cigarettes sales than the nation as a whole, and the prevalence of smoking among adults and youth has declined faster, as spending for tobacco control programs has increased….[D]uring 2001– 2010, declines in the prevalence of both adult and youth smoking in New York state outpaced declines nationally, resulting in smoking-attributable personal health care expenditures in 2010 that were $4.1 billion less than they would have been had the prevalence remained unchanged. Experience also shows that the longer the states invest in comprehensive tobacco control programs, the greater and faster the impact. In California, which has the nation's first and longest-running comprehensive state tobacco control program, the prevalence of cigarette smoking among adults declined from 22.7% in 1988 to 11.9% in 2010. (805)

In an evidence-based review of population-based tobacco prevention and control efforts, the Task Force on Community Preventive Services confirmed the **importance of coordinated and combined intervention efforts**. The strongest evidence, demonstrating the effectiveness of many of the population-based approaches that were most highly recommended by the Task Force, comes from studies in which specific strategies for smoking cessation, preventing tobacco use initiation, and eliminating exposure to secondhand smoke are combined with efforts to mobilize communities and integrate these strategies into synergistic and multicomponent efforts.

Additionally, research has shown the importance of community support, and involvement at the grassroots level, in implementing several of the most highly effective policy interventions, including increasing the unit price of tobacco products and creating smokefree environments. This community-based intervention model to create a social and legal climate, which cultivates changes in social norms around tobacco use, has now become a core element of comprehensive statewide tobacco control programs. (811)

Policies increasing the price of tobacco products work.

[I]ncreases in the prices of tobacco products, including those resulting from excise tax increases, prevent initiation of tobacco use, promote cessation, and reduce the prevalence and intensity of tobacco use among youth and adults. (827)

[W]e know that increasing the cost of cigarettes is one of the most powerful interventions we can make to prevent smoking and reduce prevalence. (Exec. Summ. Message from Kathleen Sebelius)

First, increases in cigarette prices can lead to substantial reductions in cigarette smoking. The consensus estimate from the two reviews is that a 10% increase in cigarette price will result in a 3–5% reduction in overall cigarettes consumed. Second, increases in cigarette prices will decrease not only the prevalence of smoking but also the average number of cigarettes smoked by smokers. Third, much previous research on cigarette consumption among youth suggests that both youth and young adults are more responsive than adults to changes in cigarette prices, with several studies finding youth and young adults to be two to three times as responsive to changes in price as adults. Fourth, there is greater price responsiveness among lower income populations. Finally, state excise tax increases create revenues for states. (789)

It has been suggested that one of the greatest public health consequences of the MSA was the tobacco industry's decision to increase cigarette prices after execution of the MSA. To cover the initial payments to the states and payments for the tobacco control programs under the MSA, the tobacco industry had to increase the price of cigarettes. The increase in cigarette retail prices created a decline in cigarette sales of about 10% over the next couple of years, with the most significant decrease in consumption by younger adults. (799)

Although many factors affect the final price of cigarettes and other tobacco products, the most important policy-related determinant of tobacco prices is excise taxes on tobacco products. Taxes on tobacco provide revenue to governments at a relatively low administrative cost, making these taxes especially appealing. Moreover, higher taxes have decreased consumption of tobacco products, especially cigarettes, and thereby improved public health. (788)

[The 2009 federal excise tax increase on cigarettes (and cigarette-like little cigars) from 39 cents per pack to 100.66 cents per pack] is projected to have reduced the number of middle and high school students who smoke by over 220,000 and the number using smokeless tobacco products by over 135,000. (869)

Raising prices on cigarettes is one of the most effective tobacco control interventions. Even with this tax increase in 2009, the average retail price of cigarettes in this country is still too low in comparison with other countries. Additional price increases would accelerate progress in reducing youth and young adult rates of tobacco use. (869)

Policies that prohibit smoking work.

In addition to reducing exposure to secondhand smoke, smokefree policies and laws have … been found to reduce active smoking. …[Smokefree] policies reduce the prevalence of tobacco use, increase the number of tobacco users who quit, and reduce tobacco use initiation among young people. (795)

The growth of laws regulating smoking in public locations such as schools, health care facilities, public transportation, government buildings, elevators, and restaurants has been a clear indicator of the changing social acceptability of smoking. … The progress in implementing comprehensive smokefree laws has been one of the major public health accomplishments since 1964; however, … wide geographic, occupational, and demographic disparities remain and only about one in three residents of the United States lives under state or local laws that make worksites, restaurants, and bars completely smokefree. (777)

The evidence is sufficient to conclude that smokefree indoor air policies are effective in reducing exposure to secondhand smoke and lead to less smoking among covered individuals. (827)

Smokefree laws and policies have been proven to reduce the incidence of heart attacks and other coronary events among people younger than 65 years of age, and evidence suggests that there could be a relationship between such laws and policies and a reduction in cerebrovascular events. (6-7)

[S]mokefree legislation at the **state and local levels** is a key component of a comprehensive tobacco control strategy. (792)

[A] growing body of evidence suggests that these policies have the additional benefit of lowering smoking rates among youth and young adults. There are several pathways for this effect including lower visibility of role models who smoke, fewer opportunities to smoke alone or with others, and diminished social acceptability and social advantage for smoking. One study indicated that although the prevalence of smoking and cigarette consumption was higher in people with low education and income, a cross-sectional analysis found that this group exhibited the same reductions in smoking associated with the presence of clean indoor air laws and tax increases on tobacco products as did people in higher education and income groups. (792)

For example, educating local community coalitions about the legal and technical aspects of smokefree air ordinances and enforcement can be provided most efficiently through statewide partners, who have experience in providing these services. (811)

Cessation services work.

The evidence is sufficient to conclude that tobacco cessation treatments are effective across a wide population of smokers, including those with significant mental and physical comorbidity. (827)

Smoking cessation needs increased attention. Although there has been significant progress during the last 50 years, there is a major gap between the current level of successful quit attempts and the level needed to achieve the *Healthy People 2020* goal. While adolescents and adults want to quit (70% plan to, and more than 50% try each year), far too few have been successful in quitting (about 4–6% of the smoking population as a whole succeed annually).

Utilization of proven treatments remains low among those attempting to quit, and little has been done to improve the success rates of unassisted smoking cessation efforts. Since these unaided quit attempts (e.g., called quitting “cold turkey,” or described as quitting without seeking help from health care provider, program, or other cessation services) have historically accounted for up to 90% of those who quit each year, it has been suggested that price increases, smoke-free policies, media campaigns, and other factors that decrease the social acceptability of smoking could enhance the success of these unassisted smoking cessation efforts. (846)

Model results suggest that boosting quit attempts, treatment use, and treatment effectiveness by 100% would lead to moderate to dramatic reductions in the prevalence of adult smoking, by as early as 2020, to national levels ranging as low as 6.3–11.5%. (848)

[I]ntegrating tobacco use cessation treatment with treatment for substance use disorders increases the efficacy of both efforts. (858)

[Federal law] (a) requires private insurance plans and Medicaid expansion plans to cover tobacco cessation treatments, including medications that help people quit smoking; (b) requires state Medicaid programs to cover tobacco cessation medications; (c) expands smoking cessation coverage for pregnant women who receive Medicaid; and (d) provides Medicare beneficiaries with an annual wellness visit that includes personalized prevention plan services with referrals for tobacco cessation services. (869-870)

Health systems change will play a significant role in expanding access to cessation services.

[Recent federal legislative] changes have presented significant new opportunities to institutionalize tobacco use screening and intervention and to increase the availability of evidence-based cessation treatments within health care systems. (814)

[R]ecent policy changes have focused on improving coverage of tobacco cessation treatment to prevent tobacco-related disease. The 2010 *Patient Protection and Affordable Care Act* included tobacco cessation in several sections related to disease prevention, including prohibiting states from excluding coverage for tobacco-cessation drugs from their Medicaid programs, providing coverage without cost-sharing of tobacco dependence treatment for pregnant women covered by Medicaid, and eliminating copayments for Medicare preventive services that are rated A or B by the U.S. Preventive Services Task Force (USPSTF), including tobacco use counseling for all adults. An example of this shift to prevention is also evident in the August 2010 Medicare expansion of coverage of smoking and tobacco use cessation counseling to beneficiaries who use tobacco and who do not have signs or symptoms of tobacco-related disease. (804)

[However, i]mplementation of the expanded coverage of cessation treatment mandated by Affordable Care Act varies significantly across private health insurance contracts. (804)

In addition to quitlines, CDC’s *Best Practices 2007* also recommends that statewide comprehensive tobacco control programs include health care system-based interventions. The report specifically recommends that system-based initiatives ensure that all tobacco users, who are seen in the health care system, are screened for tobacco use. Additionally, all tobacco users should receive advice to quit and should be offered brief, or more intensive, counseling service and FDA-approved cessation medication. …In summary, … brief advice by medical providers to quit smoking is an effective intervention. More intensive interventions (e.g., individual, group, or telephone) that provide social support and coaching on problem-solving skills are even more effective. Combining counseling with FDA-approved medication for smoking cessation is most effective. The Public Health Service guideline also stresses that **health care system changes**

are needed, such as covering treatment for tobacco use under both public and private insurance and eliminating cost and other barriers to treatment for underserved populations. Model programs in large managed care plans show that full implementation of health care system changes, quitline services, comprehensive insurance coverage, and promotion of the services increases the use of proven treatments and decreases the prevalence of smoking. (817)

Many have suggested that with full implementation of these strategies, far fewer youth and young adults would become smokers, and more smokers would successfully quit. The evidence reviewed in this and many previous reports document the benefits of smoking cessation. Additionally, the modeling results reviewed above show that increased access to evidence-based cessation treatments and aggressive promotion for all population groups would increase rates of successful cessation and thus reduce the consequences of smoking. With this imperative, and the opportunities provided by the *Affordable Care Act,* all groups of health care providers and systems should examine how they can establish a strong standard of care for smoking cessation for all. (851)

Mass-media anti-tobacco campaigns work

[M]ass-reach health communications interventions are effective in reducing the prevalence of smoking; increasing cessation, quit attempts, or intentions to quit; and increasing appropriate knowledge, beliefs, and attitudes regarding tobacco use. (814)

The evidence is sufficient to conclude that mass media campaigns, comprehensive community programs, and comprehensive statewide tobacco control programs prevent initiation of tobacco use and reduce the prevalence of tobacco use among youth and adults. (827)

Prior reports and reviews have shown that mass media campaigns are an effective tool to reduce the prevalence of tobacco and prevent initiation of tobacco use. [M]ass media campaigns are cost-effective [and those] designed to discourage tobacco use can change youth attitudes about tobacco use, curb smoking initiation, and encourage adult cessation, and their effects are greater when mass media campaigns are combined with other prevention efforts, such as school and/or community-based programs. (814)

Although the relative effectiveness of specific message concepts and strategies varies by target audience, research shows that countermarketing and other media approaches must have sufficient reach, frequency, and duration to be successful. (813)

The 2012 report noted that mass media campaigns are often a part of larger tobacco control programs; therefore, it is difficult to assess individual effects. Nevertheless, the report concluded that the evidence is sufficient to infer a causal relationship between adequately funded antismoking media campaigns and a reduced prevalence of smoking among youth, and that the **evidence suggests a dose-response relationship between exposure to antismoking media messages and reduced smoking behavior among youth**. (814)

Building on what works, the Surgeon General recommends implementation of the following while strategies to accelerate declines in tobacco use developed:

As end game strategies are being developed, the following actions should be implemented:

- Counteracting industry marketing by sustaining high impact national media campaigns like the CDC's Tips from Former Smokers campaign and FDA's youth prevention campaigns at a high frequency level and exposure for 12 months a year for a decade or more;
- Raising the average excise cigarette taxes to prevent youth from starting smoking and encouraging smokers to quit;
- Fulfilling the opportunity of the *Affordable Care Act* to provide access to barrier-free proven tobacco use cessation treatment including counseling and medication to all smokers, especially those with significant mental and physical comorbidities;
- Expanding smoking cessation for all smokers in primary and specialty care settings by having health care providers and systems examine how they can establish a strong standard of care for these effective treatments;
- Effective implementation of FDA's authority for tobacco product regulation in order to reduce tobacco product addictiveness and harmfulness;
- Expanding tobacco control and prevention research efforts to increase understanding of the ever changing tobacco control landscape;
- Fully funding comprehensive statewide tobacco control programs at CDC recommended levels; and
- Extending comprehensive smokefree indoor protections to 100% of the U.S. population. (875)

Ending the Tobacco Epidemic: Promising practices to accelerate declines in tobacco use

In addition to full implementation of proven tobacco control interventions, programs must consider complementary strategies likely to accelerate declines in tobacco use.

Moving forward, tobacco control policies must be as innovative as tobacco industry strategies. It is not enough to maintain the status quo.

Although more aggressive use of those evidence-based policies and programs reviewed in [this report] is a starting point, the simulation modeling results reviewed suggest that new strategies may be needed to more rapidly reduce rates of smoking. These proposed strategies have been labeled tobacco end game scenarios. (872)

Evidence-based regulation of the manufacture, sale, and marketing of tobacco products is an essential component of a comprehensive national effort to reduce the death and disease resulting from tobacco use. (787)

With intense use of proven interventions, we can save lives and reduce health care costs. (i) [L]literature considers strategies that could be used, in addition to the expanded implementation of the proven tobacco control interventions, to accelerate declines in the use of cigarettes and other combusted tobacco products and end the epidemic of disease and premature death caused by tobacco. [This has come to be called the tobacco "endgame."](852)

[A] more aggressive use of those evidence-based policies and programs reviewed in [this report] would strengthen current tobacco control measures and create a climate that enhances the feasibility of the implementation of end game strategies. Examples of end game options which could complement the proven interventions in accomplishing our overall goal of a society free of

tobacco-related death and disease include but are not limited to: (1) reducing the nicotine content to make cigarettes less addictive, and (2) greater restrictions on sales, **particularly at the local level, including bans on entire categories of tobacco products**. (856)

Promising evidence-based state and local policy options to end the tobacco epidemic: reducing exposure to tobacco point of sale marketing.

[T]he evidence is sufficient to conclude that litigation against tobacco companies has reduced tobacco use in the United States **by leading to increased product prices, restrictions on marketing methods, and making available industry documents for scientific analysis and strategic awareness**. (12)

[D]eclines in the prevalence of cigarette smoking among adults have slowed in recent years. Survey data indicate that tobacco control efforts need to not only address the population generally but also to focus on subpopulations with a higher prevalence of tobacco use and lower rates of quitting. (761)

Looking to the future, tobacco control needs to be shaped to address an increasingly heterogeneous pattern of use of tobacco products, including emerging noncombustible products, and changing demographics of users of these tobacco products. Comprehensive statewide tobacco control programs have been leading innovators in implementing culturally appropriate interventions which effectively reach and impact diverse populations with the highest prevalence of tobacco use. (857)

In addition to statewide programs, communities can also engage in strategies to address the way tobacco is promoted; **the time, manner, and place** in which it is sold; and how and where it is used, while also changing the knowledge, attitudes, and practices of tobacco users and nonusers. (811)

It is important to remember that many policy innovations in tobacco control, once thought inconceivable, have now become the law of the land. Just a decade ago, few if any, public health experts would have envisioned that 26 U.S. states and more than 30 entire countries would have legally mandated smokefree workplaces (including all restaurants and bars) in 2014. **The history of tobacco control suggests that it would be unwise not to contemplate the end game.** New developments will continue to occur, and the public health community will be far better positioned to address them if the community has thought seriously about them. (858)

Reducing exposure to tobacco product marketing, particularly at the point of sale, could have a dramatic impact on youth smoking initiation and progression to daily smoking and increase successful cessation.

Although the evidence reviewed in NCI Monograph 19 supports the efficacy of comprehensive bans on advertising, other **evidence continues to emphasize the importance of reducing existing levels of advertising and promotions in this country, particularly in any form or setting where young people can be exposed**. Specifically, the 2012 Surgeon General's report concluded **that "the evidence is sufficient to conclude that there is a causal relationship between advertising and promotional efforts of the tobacco companies and the initiation and progression of tobacco use among young people**". …[I]n addition to advertising and promotions, the 2012 report cited evidence that **the tobacco industry has invested heavily in packaging design and brand imagery on packages, which is especially influential during adolescence and young adulthood when smoking behavior and brand preferences are being developed**. (797)

At present, the tobacco retail environment serves unique roles in industry marketing and promotional activities. The 2012 Surgeon General's report found that **the presence of heavy cigarette advertising in convenience stores, especially in predominately ethnic and low-income neighborhoods, increases the likelihood of exposing youth to prosmoking messages, which can increase initiation rates among those exposed, particularly if stores are near schools**. Therefore, based upon the findings in the 2012 report, local policies and approaches to reduce point-of-purchase advertising and promotions have increased. (797)

[F]rom a cost-benefit point of view, the potential public health advantages and associated economic gains (such as in long-term worker productivity) of banning cigarette advertising are far greater than the private costs to tobacco companies and advertisers of any lost revenues; consequently, it has been suggested that an advertising ban would be sensible from an economic perspective. (797)

The Surgeon General's reports published in 2012 and 2014 include substantial evidence that tobacco product marketing at the point of sale is a major cause of youth smoking and undermines cessation. Based on the evidence, state and local governments may consider implementing restrictions on the time, place or manner of tobacco product marketing in order to prevent youth initiation and enhance quit attempts.

Restricting the number, type and location of tobacco retailers

As previous Surgeon General's reports confirm, tobacco retail outlets, and the associated tobacco marketing (including product promotions), have a significant impact on adolescent tobacco use. Tobacco advertising is more prevalent in stores located near schools.[3] Additionally, schools with higher rates of student smoking tend to be surrounded by a larger number of tobacco retailers.[4] In 2011, there were approximately 23,000 tobacco retail stores in New York State – one for every 185 kids.[5] Additionally, 51% of those retailers are located within 1,000 feet of an elementary or secondary school.[6] Thus, reducing the number and regulating the location of these retailers is key to combating youth tobacco use. Specific regulatory policies might include the use of retail licensing systems, zoning laws, or direct restrictions on the sale of tobacco products.[7]

Tobacco Retail Licensing

A license is a mechanism through which a state or local government grants permission to do something that may otherwise be unlawful. Through the implementation of a licensing system for tobacco retailers, a state or local government may restrict the number, location and the type of retailers that are legally permitted to sell tobacco products in the jurisdiction.

Number: In order to address the pervasiveness of tobacco sales and marketing, a community might decide to limit the total number of tobacco retail licenses that will be issued.

Location: In order to protect children from exposure to tobacco marketing, a community could require that tobacco retailers be located a minimum distance from schools, playgrounds, and other youth-oriented facilities.

In order to address the density of tobacco retailers, a community could also require tobacco retailers to be located a minimum distance from one another.

Type: A licensing system could prohibit certain types of retail outlets from selling tobacco products. The 2012 Surgeon General's Report noted that pharmacies are facing an "incongruity between their primary role in health care and the negative effects of tobacco products on health." Several localities in Massachusetts and California have already prohibited tobacco sales by pharmacies.[8]

Additional Conditions: A license may also require tobacco retailers to comply with other legal obligations. For example, a license could be conditioned on compliance with existing laws regarding youth access to tobacco products, or it could be tied to new restrictions on the marketing of tobacco products.[9]

A licensing system provides a community with a powerful enforcement tool—retailers who violate the conditions of the license could lose the privilege of selling tobacco products. New York State currently requires all tobacco retailers to register with the state.[10] This registration may be revoked if the retailer is convicted of a violation of a youth-related tobacco law or other enumerated laws. New York State could strengthen its registration law by incorporating restrictions on the number, type, and location of tobacco retailers.

Local governments in New York can also adopt their own licensing systems. Licenses have been used to regulate businesses of all types; thus, in most communities, it is a familiar regulatory device. Moreover, a fee may be imposed on licensees to cover the costs of the administration and enforcement of the licensing system, making it economically feasible. Dutchess and Cayuga Counties and New York City have implemented licensing schemes for tobacco retailers within their jurisdictions. The licensing systems in Dutchess County and New York City act primarily to ensure retailer compliance with youth-related tobacco laws. Cayuga County has incorporated location restrictions within its licensing system and new retailers within 100 feet of schools are ineligible for a license. These systems, too, could be strengthened by incorporating some of the other restrictions discussed above.

Zoning laws

Zoning laws (also referred to as land use regulations) may also be an effective tool through which local governments can regulate the number and location of tobacco retailers. The purpose of zoning laws is to regulate the use of land within a particular jurisdiction. A jurisdiction is generally organized into particular districts or zones, and the law identifies specific uses that are permitted within each zone. These uses might be permitted "as-of-right" (e.g., a single family home in a residential district) or might be made a conditional use. A landowner must apply for a special permit (a "conditional use permit") before using his or her land for a purpose identified as conditional use. A zoning law could identify tobacco sales as a conditional use of land and require a permit before a new tobacco retail outlet can be established. The law could also set eligibility requirements for the issuance of a permit. For example, a law could require new tobacco retailers to locate a certain distance away from residential zones, schools or other areas frequented by youth, or other tobacco retailers. A zoning ordinance could also limit the number of conditional use permits that will be granted for tobacco retailers. In this manner, a local government might, over time, reduce the number, density, and location of tobacco retailers within its jurisdiction. Recently, the cities of Rochester and Binghamton adopted zoning laws that impose location restrictions on tobacco retailers. Specifically, the City of Rochester requires new tobacco retailers to locate at least 500 feet from schools and other "protected" areas frequented by youth, as well as other tobacco retailers. Binghamton requires new tobacco retailers to locate more than 500 feet from schools. Existing retailers in both cities are exempted from the new requirements.

Zoning law is generally a prospective policy solution. A community wishing to impose new zoning restrictions on existing tobacco retailers must include a "reasonable" period of time for those businesses to comply with the new law. Even those that only apply to new businesses, however, may be effective as a long-term solution as older businesses are replaced by newer ones (which will be subject to the new zoning law).

Direct Regulation

Under the 2009 Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act), state and local governments maintain the authority to regulate the sale and distribution of tobacco products.[11] Thus, a state or local government could directly limit the type of retailers that are allowed to sell tobacco products. For example, a law might specifically prohibit pharmacies or other health care facilities from selling any tobacco products. In this manner, governments could address the contradictory messages sent by pharmacies when they offer tobacco products alongside pharmaceutical products meant to address illnesses caused by, or exacerbated by, tobacco use. At the same time, prohibiting tobacco sales by pharmacies can produce an immediate reduction in the number and the density of tobacco retailers.

Restricting Product Pricing

Congress and state governments (as well as some local governments, including New York City) have imposed taxes on tobacco products that increase the purchase price of those products and benefit public health by reducing consumption. Tobacco companies have responded by crafting innovative price-reducing strategies to retain current users and recruit new ones. These strategies include the use of coupons and multi-pack offers, as well as the payment of promotional and other allowances to retailers and wholesalers. Price promotions are attractive to certain price-sensitive consumers—not coincidentally, these consumers are also those disparately impacted by tobacco. The state and local communities could directly regulate these price promotions, or they could amend their minimum price laws to address this issue.[12]

> [T]he tobacco industry has used a mixture of actions to alter the prices of their products, including a variety of price-reducing promo¬tions, and that these actions attract price-sensitive populations such as youth to their products, as well as soften the price impact on consumers of increases in federal and state tobacco excise taxes. In addition to pricing policies, the report reviewed the evidence that tobacco manufacturers have employed a wide range of advertising, marketing, and promotional initiatives which have been shown to be key factors in initiation and progression of tobacco use among youth and young adults. **[T]obacco advertising and promotion,** particu-larly those initiatives containing imagery which associates positive qualities with tobacco use and **impacts attitudes about smoking, intentions to smoke, and actual smoking behavior among youth**. …[T]he tobacco industry has invested heavily in **packaging design and brand imagery on packages, which is especially influential during adolescence and young adult-hood when smoking behavior and brand preferences are being developed.** (797)

Regulation of Price Promotions

State and local governments can directly regulate the use of pricing promotions. By doing so, they can keep the price of tobacco products higher, thereby reducing tobacco use in their jurisdiction. Such regulation might come in the form of restrictions on coupon redemption, the use of multi-pack and cross-promotions, or promotional allowances paid to retailers and wholesalers. A combination approach may be the most beneficial so that industry resources are not simply redirected to alternative price reduction strategies.

Under the Tobacco Control Act, state and local governments have the authority to regulate the time, place and manner of cigarette promotions,

but not the content of those promotions.[13]

Thus, any restriction on price promotions should be drafted narrowly such that it clearly restricts only the "manner" or type of promotion, and not the content of any advertisement.[14] Similarly, in order to avoid potential First Amendment concerns, such restrictions should avoid restricting the content of promotional speech and should focus narrowly on prohibiting certain types of transactions.[15]

New York City and Providence, Rhode Island, have each implemented restrictions on the redemption of coupons and other price-reducing promotions within their respective jurisdictions.[16] Each of these laws was challenged by the tobacco industry, and each was upheld by the court.[17]

Minimum prices

Many states have employed the use of minimum price laws to prohibit retailers from selling tobacco products below a statutory minimum. Existing minimum price laws primarily regulate the price of cigarettes only, and many have loopholes to allow the use of discounting mechanisms to reduce the price. New York State's Cigarette Marketing Standards Act provides a specific formula for calculating the minimum price at which cigarettes may be sold. The law prohibits retailer or wholesaler price discounts that reduce the price of cigarettes below the statutory minimum, but it does not prohibit other discounting strategies (such as the use of coupons) that reduce the price of cigarettes below the statutory minimum. New York could strengthen its minimum price law by limiting or prohibiting price discounting mechanisms such as coupons, multipack discounts, and cross-promotions (where one tobacco product is included with the purchase of another tobacco product).

Restrict sales of tobacco products.

> [T]he Tobacco Control Act specifically forbids FDA from banning cigarette sales. [However], the prohibition of FDA banning categories of products in the Tobacco Control Act does not apply to states or localities. **[E]very state (and municipality) in the United States has the power to ban the sale of cigarettes, a power upheld by the U.S. Supreme Court in Austin vs. The State of Tennessee.** (854)
>
> [A] simulation model of multiple influences projected a sizeable benefit of a mentholated cigarette ban with 323,000 deaths averted from 2011–2050, a third of them among African Americans, assuming an impact on initiation and cessation of 10%. (787)

New York City[18] and Providence, Rhode Island[19] have each implemented restrictions on flavored tobacco products, with the exception of menthol-flavored products. While the FDA Act prohibits the sale of cigarettes with a characterizing flavor (with the exception of menthol), the federal prohibition does not extend to other tobacco products. Importantly, state and local governments are not required to permit the sale of menthol products. Chicago, for example, prohibits the sale of menthol and other flavored tobacco products within 500 feet of schools.[20] Thus, these local laws fill a gap in federal law and prohibit the sale of products that are of particular interest to youth and other vulnerable populations.

Eliminate portrayals of smoking in movies rated for youth.

Youth who are exposed to images of smoking in movies are more likely to smoke; those who get the most exposure to onscreen smoking are about twice as likely to begin smoking as those who get the least exposure (15)

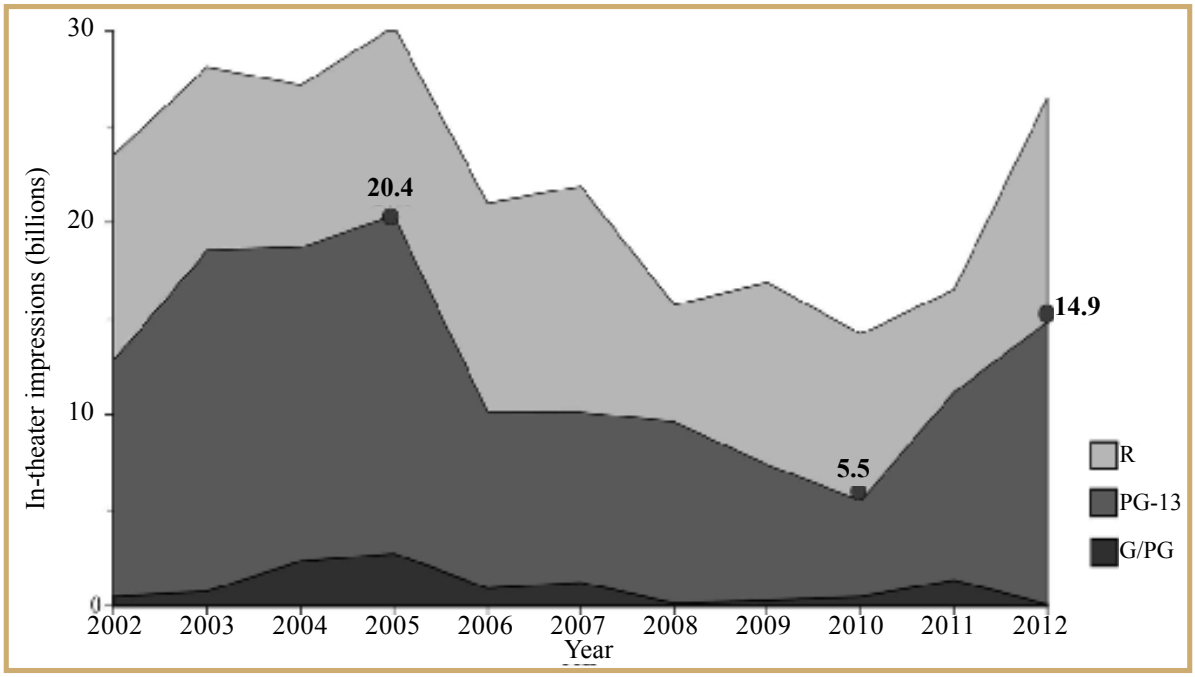
Portrayals of tobacco use in U.S. films appear to have rebounded upward in the past 2 years. (15)

Based on the findings in the 2012 Surgeon General's report that there is a causal relationship between the depictions of smoking in the movies and initiation of smoking among young people, actions that would eliminate depiction of tobacco use in movies that are produced and rated as appropriate for children and adolescents could have a significant effect toward preventing youth from becoming tobacco users. (797-8)

[B]ecause smoking in movies is such a major source of protobacco media exposure, if smoking in PG-13-rated movies was reduced to the fifth percentile of exposure, youth smoking rates could be reduced by 18%. The magnitude of this effect would be similar to an increase in the price of cigarettes from about $6.00 per pack to over $7.50 average price. (813)

In addition to actions taken by the federal govern¬ment, actions by national and local nongovernmental organizations can have significant impacts on social norms. …[T]he portrayals of tobacco use in U.S. films appear to have rebounded upward in the last 2 years. Based on box office attendance data, it has been estimated that youth were exposed to 14.9 million in-theater tobacco-use impressions in youth-rated films in 2012. Youth who are exposed to images of smoking in movies are more likely to smoke; those who experience the most exposure to onscreen smoking are approximately twice as likely to begin smoking as those who receive the least exposure. (872-873)

Figure 3. Tobacco impressions delivered by top-grossing U.S. movies, by Motion picture Association of America rating



(776) (One impression equals one tobacco use incident on screen viewed by one audience member.)

While tobacco companies that joined the tobacco Master Settlement Agreement are prohibited from offering paid or incentivized product placement in movies or other productions, these restrictions do not affect the general portrayal of tobacco use. It may not be legally feasible for government to require adult ratings for movies or television programs that portray tobacco use; instead private agencies that approve ratings for movies and television shows must change the criteria for youth-rated shows. Thus far, the rating agencies have resisted making effective changes despite advocacy efforts by a broad-based coalition (including the World Health Organization, Legacy Foundation, American Heart Association, American Lung Association, American Public Health Association, medical organizations, Attorneys General, and health departments).[21]

Movie Ratings

Movies are rated by the Board of the Classification and Rating Administration, which is an independent division of the Motion Picture Association of America (MPAA).[22] The board consists of parents (each member must have a child between the ages of 5 and 15 upon joining and must leave the board when all children have reached the age of 21) who have no other affiliation with the entertainment industry. [23] The Board assigns ratings determined to best reflect the view of most American parents. [24]

As a result of growing parental concerns about depictions of smoking in movies such depictions have been considered as factors in the ratings process since 2007.[25] However, such depictions do not require the assignment of any particular rating. [26] Rather, the board considers whether smoking is pervasive in a film, whether it is glamorized, and whether there is a historic, public health, or other context that mitigates its depiction. [27]

While there has been some advocacy to require movies that depict smoking to be assigned an R rating,[28] the MPAA has resisted making such a ratings change. [29] There is precedent for such automatic ratings for certain content. For example, any drug use requires at least a PG-13 rating, and a single use of one of the "harsher sexually-derived words," even if used only as an expletive, requires at least a PG-13 rating.[30] More than one use of such an expletive, or the single use of such an expletive in a sexual context, requires an R rating. [31]

Advocacy organizations have proposed other policy changes that could reduce youth exposure to smoking imagery in movies. These include strong anti-tobacco message or advertisements (not produced by tobacco companies); requiring producers to certify that there were no payoffs to induce the inclusion of smoking in the movie; ending tobacco brand display on screen (e.g., billboards or other imagery in the background); and making productions with tobacco imagery ineligible for public subsidies.[32]

Any member of the public may make proposals to revise the rules pertaining to movie ratings.[33] Proposals must be made to the CEO of the MPAA and the President of the National Association of Theatre Operators (NATO).[34]

Motion Picture Association of America
200 White Plains Road, 1st Floor
Tarrytown, NY 10591
(914) 333-8892 (main)
(914) 333-7541 (fax)
ContactUs@mpaa.org

National Association of Theatre Owners
750 First Street, NE
Washington, DC 20002
(202)-962-0054 (main)
(202) 962-0370 (fax)

Television Ratings

The TV Parental Guidelines Monitoring Board is responsible for creating the ratings categories for television shows and for ensuring that those who assign ratings to television programs (e.g., program producers or broadcasters) do so accurately and consistently. [35] The Board consists of experts from the television industry and public interest advocates.

Currently, smoking is not considered as a factor in the ratings process. However, the Board is open to comments, complaints and suggestions—including the suggestion that shows containing portrayals of smoking are rated for mature audiences:

TV Parental Guidelines
P.O. box 14097
Washington, DC 20004
tvomb@usa.net

TIME-LINE OF NEW YORK TOBACCO EVENTS

1989	New York Clean Indoor Air Act (CIAA) prohibits smoking in some public places and requires all workplaces to have a policy on where smoking can occur.
1990	New York cigarette excise tax is raised to $0.39
1992	Adolescent Tobacco Use Prevention Act (ATUPA) becomes law, prohibiting tobacco sales to minors and defining penalties for violators
1993	New York cigarette excise tax is raised to $.56.
1994	New York CIAA amended to restrict smoking in educational institutions.
1995	New York enacts the Cigarette Marketing Standards Act (CMSA) prohibiting the sale of cigarettes below cost and making it illegal for retailers to avoid collection or payment of taxes. (source)
1997	ATUPA strengthened and funded to provide at least one compliance check of every tobacco retailer annually

New York's Tobacco Control Program

The Surgeon General's report identifies several key components to an effective comprehensive tobacco control program. Specifically, it concludes that effective comprehensive programs include the three following "overarching intervention components" – state and community interventions, health communication interventions, and cessation interventions. (806) The CDC identifies this strategy as the "guiding principal" for tobacco control and is the approach that New York State takes in its tobacco control efforts. (805) New York State has been at the forefront of tobacco control and has implemented many policies recommended by the Surgeon General. Moreover, the state is positioning itself for the implementation of promising evidence-based policies, such as those that reduce youth exposure to point of sale marketing—which the Surgeon General has concluded is a cause of youth initiation of smoking.[37]

Comprehensive Tobacco Control Programs

The Surgeon General identifies the goals of a comprehensive tobacco control program as (1) preventing youth and young adult initiation, (2) promoting quitting among youth and adults, (3) eliminating exposure to secondhand smoke, and (4) identifying and eliminating tobacco related disparities among population groups. (806) New York State, modeling their tobacco control program on the CDC's best practices, has made great strides towards these goals. The state's tobacco control efforts have resulted in a signification drop in high school smoking prevalence from 27.1% in 2000 to 11.9% in 2012.[38] Moreover, the state maintains the fifth lowest adult tobacco use rate in the country.[39] Despite low rates of youth and adult smoking in the state, however, there are opportunities for the state to further reduce rates of smoking among specific populations such as those with lower incomes, lower educational attainment or serious mental illness.[40]

Program Funding

A comprehensive program is one that is funded as an ongoing public health effort. (804) When compared to national rates, evidence demonstrates that states with larger investments in comprehensive tobacco control programs see lager declines in cigarette sales and a faster decline in the prevalence of smoking among adults and youth as spending on tobacco control programs increases. (805)

1999	Centers for Disease Control and Prevention (CDC) launches the National Tobacco Control Program, supporting tobacco control programs in 50 states. New York awarded $2 million a year for five years for comprehensive tobacco control.
1999	New York Medicaid program provides coverage for tobacco dependence treatment medications
2000	New York Cigarette Fire Safety Act becomes law, initiating regulator process; negotiations go into effect in 2004.
2000	New York State Smokers' Quitline established, offering free coaching and support to quit smoking.
2000	New York cigarette excise tax is raised to $1.11
2001	Tobacco product placement law enacted, requiring all tobacco products to be inaccessible to the consumer.
2001	American Legacy Foundation funds a national Youth Empowerment Program. New York awarded $1 million a year for three years for youth programs.

This is evident in New York where during 2001-2010 the prevalence of youth and adult smoking declined faster than the national prevalence rates. (805) This led to a savings of $4.1 billion in health care expenditures. (805)

Adequate funding is required to continue to maximize tobacco control program success. (852) Despite this recommendation, states spend a minuscule portion of their tobacco revenues on their tobacco control programs. (852) New York dedicates more funding to its tobacco control program than most of its neighbors, but does not meet the CDC's recommended level of tobacco control program funding. During fiscal year 2014, New York designated $41,522,539 of funding to the state tobacco control program —equal to 16.3% of the $254,300,000 recommended by the CDC [41] and only 1.8% of the state's estimated tobacco revenue for fiscal year 2014.[42]

Comparatively, New York designated a higher percentage of CDC recommended funding than most neighboring states in the region including New Jersey (2.1%), Pennsylvania (6.2%), Connecticut (11%), Massachusetts (7.2%), and Rhode Island (13.6%). Only one neighboring state, Vermont (52.2%), funded its tobacco control program more closely to the CDC recommending funding level.

State and local efforts

Successful comprehensive tobacco control programs engage in both state and local level programming. The Surgeon General's report has found that "[t]he history of successful public health practice has demonstrated that the active and coordinated involvement of a wide range of societal and community resources is the foundation of sustained solutions to pervasive problems, like tobacco use." (811)

Many of the most effective tobacco control polices, such as increasing the price of tobacco products and limiting exposure to secondhand smoke, require community support and grassroots involvement. (811)

New York has been a leader in maintaining high prices of tobacco products and reducing secondhand smoke exposure. New York State currently imposes a $4.35 excise tax on cigarettes, the highest state cigarette tax in the country. New York has prohibited smoking in bars and restaurants since 2003 and has implemented protections from unwanted exposure to secondhand smoke to a wide array of both indoor and outdoor locations throughout the state.

2002	New York cigarette Excise tax is raised to $1.50, tax on all other tobacco products increased to 37% of wholesale price. Law prohibiting common carriers from delivering cigarettes to New York residents is enacted.
2003	New York CIAA amended to prohibit smoking in all work and public places, including restaurants and bars.
2004	New York passes first fire-safe cigarette law, requiring cigarettes to have fire-retardant brands in the paper wrapper that slow burn rates and prevent accidental fires
2004	New York State Smokers' Quitline offers free starter kits of nicotine patches, gum or lozenge.
2005	NY Attorney General reaches agreement with credit card companies to not process online tobacco transactions. NY Attorney general reaches agreement with publishers of Time Magazine, Newsweek, People, and Sports illustrated to remove tobacco ads from magazines sent to schools
2006	RJ Reynolds Tobacco Company and Attorney General end sale of candy, fruit, and alcohol flavored cigarettes

The New York Bureau of Tobacco Control works through a network of statewide contractors to educate communities and build grassroots support for policy change to reduce the mortality and morbidity caused by tobacco use. Specifically, the Bureau works to accomplish the following priorities:

- Prevent initiation of tobacco use by youth and young adults, especially among low socioeconomic status (SES) populations.
- Reduce tobacco use among adults with low incomes, low educational attainment or serious mental illness.
- Eliminate exposure to secondhand smoke.
- Maintain, strengthen and refine New York's effective tobacco control infrastructure.
- Contribute to the science of tobacco control.
- Bureau contractors work to change the community environment to support policy change that will:
- Reduce the negative impact of tobacco product marketing and price promotions on youth and adults at the point of sale.
- Reduce tobacco use in outdoor areas.
- Decrease secondhand smoke exposure in multi-unit housing, with an emphasis on policies that protect the health of low-income residents.
- Promote policies that reduce tobacco use imagery in youth-rated movies, and on the Internet and social media.

Next Generation Policies

New York communities are beginning to understand that the status quo is unacceptable when it comes to reducing tobacco use and improving public health—and they are responding with innovative policies like those described in Section III. Some examples are:

New York City:

STEP
The "Sensible Tobacco Enforcement Policies" (STEP) is designed to combat illegal cigarette smuggling and impose certain pricing restrictions on tobacco product sales. The law increases penalties for retailers who evade cigarette taxes or sell without a license; prohibits retailers from redeeming coupons or honoring other price discounts for cigarettes and tobacco products; establishes a price floor for cigarettes and little cigars; requires cheap cigars be sold in packages of at least four; and requires little cigars be sold in packages of at least twenty. This law took effect on March 19, 2014, and enforcement began on August 1, 2014.

2008	CIAA amended to prohibit smoking in dormitories, residence halls, and other group residential facilities that are owned or operated by colleges, universities, and other educational intuitions. NY Office of Alcoholism and Substance Abuse Services implements regulations that require all substance abuse treatment facilities to treat tobacco use and dependence and maintain tobacco-free grounds
2008	Cigarette excise tax is raised to $2.75.
2009	Congress authorizes the biggest federal tobacco excise tax in U.S. history, raising it to $1.00
2010	New York cigarette excise tax raised to $4.35
2010	NYS TCP receives federal stimulus funding to reduce the impact to tobacco marketing on youth.
2010	The federal Prevent All Cigarette Trafficking Act (PACT Act) becomes effecting- requiring registration and reporting requirements for those who sell, transfer, ship, advertise, or offer to sell cigarettes and smokeless tobacco in interstate commerce. (source)

Tobacco 21
New York City was the first major city or state in the U.S. to adopt a minimum purchase age of 21. This law increases the purchase age from eighteen to twenty-one years for cigarettes and tobacco products, including electronic cigarettes (e-cigarettes). This law took effect May 18, 2014.

SFAA
In 2013, New York City amended its Smoke-Free Air Act, extending the law to include e-cigarettes. The Smoke-Free Air Act bans smoking in public places such as restaurants, bars, parks, beaches, and places of employment. It now also prohibits the use of e-cigarettes, which are not yet regulated by the FDA, in those areas where smoking is prohibited. This law took effect April 29, 2014.

Flavored Tobacco
New York City prohibits the sale of flavored non-cigarette tobacco products. Prohibited flavors include including fruit, chocolate, vanilla, honey, candy, cocoa, dessert, alcoholic beverage, herb, or spice. The sale of flavored cigarettes is prohibited under federal law. This law took effect February 25, 2010.

Cayuga County:

Tobacco Retail Licensing
Cayuga County implemented a local tobacco retail licensing scheme that requires all retailers selling tobacco products obtain a license from the County Department of Health and Human Services. Beginning in 2015, the county will refuse new licenses to any retailer within 100 feet of any school. This provision will serve to gradually reduce the density of tobacco retailers in immediate proximity to schools. This law took effect January 2014.

Rochester:

Zoning
In 2012, Rochester became the first municipality in New York State to incorporate measures to regulate the location and density of tobacco retailers into its zoning laws. Specifically, Rochester's zoning law requires new tobacco retailers to be located at least 500 feet from any "protected use" (including schools) and any other tobacco retailer. This law took effect November 1, 2012.

2012	Surgeon General's report concludes that tobacco marketing causes smoking among youth and young adults.
2012	ATUPA amended to prohibit sale of e-cigarettes to individuals under the age of 18. (source)
2013	New York City becomes the first major city to raise the legal age for the purchase of tobacco products to 21.
2013	Cayuga County becomes the first New York jurisdiction to prohibit new tobacco retailers from locating near schools through a new retailer licensing system.
2014	City of Binghamton imposes location restrictions on new tobacco retailers through city zoning code, imposing minimum distance from schools.

Binghamton:

Zoning
Binghamton implemented an amendment to the city zoning code that prohibits any new tobacco retailer from locating within 500 feet of the property boundary of any public or private elementary or secondary school. This law took effect April 2014.

The Bureau of Tobacco Control, through its contractors—including the Center for Public Health and Tobacco Policy—provides technical assistance and educational support for this kind of policy change. For more information about these and other tobacco control policies, please visit the Center's website at www.tobaccopolicycenter.org or contact our office directly.

Conclusion

The Health Consequences of Smoking—50 Years of Progress recounts the incredible success of tobacco control policy to date and identifies the next steps necessary to accelerate the decline in tobacco use. We know what works—comprehensive state and local tobacco control programs, high prices on tobacco products, smoke-free air policies, mass media anti-tobacco campaigns and access to cessation services effectively reduce smoking rates and increase cessation rates. However, these policies are not currently implemented at their most effective levels, resulting in stagnation in tobacco consumption rates. The industry continues to perpetuate the tobacco epidemic to maximize profit, and federal, state and local governments must counteract industry tactics through effective implementation of strong tobacco control policies. The Surgeon General urges state and local communities to *fully fund* tobacco control programs and use the authority granted them to implement innovative policies, like sales restrictions on entire categories of tobacco products (e.g., flavored products). Progressive policy change, like those implemented before them, will help us to finally realize an end to the tobacco epidemic.

New York State has been a leader in U.S. tobacco control. It maintains one of the most comprehensive tobacco control programs and, as a result of robust policy initiatives, has reduced adult smoking rates to 18.1%--the fifth lowest rate in the country—and that of high school students to 11.9%. Nevertheless, the state funds its program at only 16.3% of the CDC-recommended level. While the state is making phenomenal strides in reducing smoking rates, the state and its local communities likely would benefit from some of the innovative policies identified by the Surgeon General and in this guide.

The tobacco product sales and promotion policies described in Section III of this guide can be used by New York and elsewhere to reduce exposure to tobacco product marketing and improve public health in measurable ways. For more information about these and other tobacco control policies, please visit the Center for Public Health and Tobacco Policy's website at www.tobaccopolicycenter.org or contact our office directly.

Notes

[1] Hanna Dreier, *Prop 29 Fails: CA Cigarette Tax Loses by Less than a Percentage Point*, Huffington Post (June 22, 2012).
[2] *See* NATO v. City of New York, 2014 WL 2766593 (SDNY June 18, 2014); *see also* U.S. Smokeless Tobacco Manufacturing Company v. City of New York, 703 F. Supp.2d 329 (SDNY 2010) (summary judgment denied but not reported 2011 WL 5569431).
[3] U.S. Dep't. of Health & Human Servs. , Preventing Tobacco Use Among Youth and Young Adults, a Report of the Surgeon General 600 (2012) [hereinafter 2012 Surgeon General's Report].
[4] Scott T. Leatherdale & Jocelyn M. Strath, *Tobacco Retailer Density Surrounding Schools and Cigarette Access Behaviors Among Underage Smoking Students*, 33 Annals of Behav. Med., 105, 106 (2007).
[5] *See* N.Y. State Dep't of Health, Exposure to Pro-Tobacco marketing and Promotions Among New Yorkers 23 (2011), *available at* http://www.health.ny.gov/prevention/tobacco_control/dovs/tobacco_marketing_exposure_rpt.pdf; *see also* U.S. Census Bureau, State and County Quickfacts, http://quickfacts.census.gov/qfd/states/36000.html.
[6] Douglas A. Luke, et al., *Family Smoking Prevention and Tobacco Control Act: Banning Outdoor Tobacco Advertising Near Schools and Playgrounds*, 40 Am. J. Prev. Med. 295, 300 (2011).
[7] For more information about these types of policies, please see Center for Public Health and Tobacco Policy, Tobacco retail Licensing: Local Regulation of the Number, Location and Type of Tobacco Retail Establishments in New York, *available at* http://www.tobaccopolicycenter.org/documents/Final%20Licensing%20Report%202014.pdf; *see also* the Center for Public Health and Tobacco Policy's other resources concerning tobacco marketing at the point of sale, *available at* http://tobaccopolicycenter.org/tobacco-control/retail-environment/.
[8] A prohibition on tobacco sales by pharmacies could also be enacted through direct regulation.
[9] Certain limits on advertising and marketing may raise First Amendment concerns, and should be discussed with the Center for Public Health and Tobacco Policy or other policy center or attorney.
[10] New York Tax Law §480a (2012).
[11] 21 U.S.C. 387p (2012).
[12] For more information, please see Center for Public Health and Tobacco Policy, Tobacco Price Promotion: Policy Responses to Industry Price Manipulation, *available at* http://www.tobaccopolicycenter.org/documents/Tobacco%20Price%20Promotion%20Complete%20Report.pdf.
[13] 15 U.S.C. 1334 (2012).
[14] *See, e.g.,* Center for Public Health and Tobacco Control, Tobacco Price Promotion: Local Regulation of Discount Coupons and Certain Value-Added Sales, *available at* http://www.tobaccopolicycenter.org/documents/TR-COUPON%20FINAL.pdf.
[15] The First Amendment of the United States Constitution provides some protection for commercial speech, but the protection is not absolute. *See* Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc., 425 U.S. 748, 770 (1976) ("In concluding that commercial speech, like other varieties, is protected, we of course do not hold that it can never be regulated in any way. Some forms of commercial speech regulation are surely permissible.").
[16] New York, N.Y. Admin. Code §17-176.1(2014); Providence, RI, Code of Ordinances §14-303.
[17] National Ass'n of Tobacco Outlets, Inc., v. City of New York, 2014 WL 2766593, 13-16 (June 18, 2014; National Ass'n of Tobacco Outlets, Inc., v. City of Providence, RI, 731 F.3d 71 (2013).
[18] New York, NY Admin. Code §17-715.
[19] Providence, RI Code of Ord. §14-309.
[20] Chicago, IL, Code § 4-64-180.
[21] *See* Legacy Foundation, *Smoking in Youth-Rated Movies Has Doubled Since 2010* (April 9, 2013), *available at* http://www.legacyforhealth.org/newsroom/press-releases/smoking-in-youth-rated-movies-has-doubled-since-2010/%28language%29/eng-US.
[22] MPAA, Classification and Rating Rules 1 (January 1, 2010), *available at* http://www.filmratings.com/filmRatings_Cara/downloads/pdf/ratings/cara_rating_rules.pdf.
[23] *Id*. at 2.
[24] *Id*. at 6.

[25] William Triplett, *Smoking in Movies to Affect Ratings*, Variety, May 10, 2007, *available at* http://variety.com/2007/film/news/smoking-in-movies-to-affect-ratings-1117964655/.
[26] *Id.*
[27] *Id.*
[28] *See* Amanda Gardner, *Should Smoking Trigger an R Rating?*, Health.com (July 13, 2012), *available at* http://www.cnn.com/2012/07/10/health/smoking-trigger-rating-movie.
[29] David Germain, *MPAA Adds Smoking as Film-Ratings Factor*, Washington Post (May 10, 2007), http://www.washingtonpost.com/wp-dyn/content/article/2007/05/10/AR2007051001876.html.
[30] MPAA, *supra* note 22 at 7-8.
[31] *Id*.
[32] Legacy Foundation, *Smoking in Youth-Rated Movies Has Doubled Since 2010* (April 9, 2013), *available at* http://www.legacyforhealth.org/newsroom/press-releases/smoking-in-youth-rated-movies-has-doubled-since-2010/%28language%29/eng-US.
[33] *Id*. at 23.
[34] *Id.*
[35] TV Parental Guidelines, Frequently Asked Questions, http://tvguidelines.org/faqs.htm
[36] *See* TV Parental Guidelines, Understanding the TV Ratings, http://tvguidelines.org/ratings.htm
[37] 2012 Surgeon General's Report *supra* note 3at 508.
[38] New York State Department of Health, Trends in Youth Smoking (2013), http://www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume6/n2_trends_in_smoking_prevalence_among_new_york_youth.pdf.
[39] New York State Department of Health, Smoking and Tobacco Use – Cigarettes and Other Tobacco Products, https://www.health.ny.gov/prevention/tobacco_control/.
[40] *Id*.
[41] American Lung Association, State of Tobacco Control, *available at* http://www.stateoftobaccocontrol.org/state-grades/new-york/.
[42] Ann Boonn, Campaign for Tobacco Free Kids, State Tobacco-Related Costs and Revenues (Jan. 6, 2014), *available at* http://www.tobaccofreekids.org/research/factsheets/pdf/0178.pdf.

Center for Public Health and Tobacco Policy

Providing legal expertise to support tobacco control policy.

The Center for Public Health and Tobacco Policy (Center) is a resource for the New York State and Vermont communities and is funded through the New York State and Vermont Departments of Health.

What we do

Research & Information Services

- provide the latest news on tobacco law and policy through our legal and policy reports, fact sheets, quarterly newsletters, and website

Policy Development & Technical Assistance

- respond to specific law and policy questions from the Vermont and New York State Tobacco Control Programs and their community coalitions and contractors, including those arising from their educational outreach to public health officials and policymakers
- assist local governments and state legislators in their development of initiatives to reduce tobacco use
- develop model ordinances for local communities and model policies for businesses and school districts

Education & Outreach

- participate in conferences for government employees, attorneys, and advocates regarding critical initiatives and legal developments in tobacco policy
- conduct smaller workshops, trainings webinars, and presentations focused on particular policy areas
- impact the development of tobacco law through *amicus curiae* ("friend of the court") briefs in important litigation

Find us online

www.tobaccopolicycenter.org

The Center's website provides information about recent tobacco news and case law, New York and Vermont tobacco-related laws, and more. Current project pages include: tobacco-free outdoor areas; tobacco product taxation; smoke-free multiunit housing; and retail environment policies. The website also provides convenient access to reports, model policies, fact sheets, and newsletters released by the Center.

http://twitter.com/CPHTP
https://www.facebook.com/CPHTP

Follow us on Twitter and Facebook for informal updates on the Center and current events.

Requests for Assistance

The Center is funded to support the Vermont and New York State Tobacco Control Programs, the New York State Cancer Prevention Program and community coalitions. The Center also assists local governments and other entities as part of contractor-submitted requests. If we can help with a tobacco-related legal or policy issue, please contact us.

The Center provides educational information and policy support. The Center does not represent clients or provide legal advice.

Center for Public Health and Tobacco Policy

at Northeastern University Law School
360 Huntington Avenue, #117CU
Boston, MA 02115
T: 617-373-8494
tobacco@tobaccopolicycenter.org
www.tobaccopolicycenter.org