TOWARD A TOBACCO-FREE CALIFORNIA

2003–2005

The Myth of Victory

MASTER PLAN

OF THE TOBACCO EDUCATION AND RESEARCH OVERSIGHT COMMITTEE

JANUARY 2003

Foreword

The Tobacco Education and Research Oversight Committee (TEROC) presents this sixth three-year Master Plan for California's Tobacco Control Program, pursuant to its legislative mandate (California Health and Safety Code Section 104350-104480). In this document, we set forth objectives and highlight the Program's accomplishments since 2000. We have based our recommendations on the proven effectiveness of California's focus on policies that change social norms about tobacco products and tobacco's place in society.

TEROC's long-term goal is to reduce adult smoking prevalence in California to 10% and youth prevalence to 2% by 2007. (TEROC's intermediate goal in this Master Plan is to reduce adult smoking prevalence in California to 13% and youth prevalence to 4% by the end of 2005.) Past experience in California demonstrates that our goal is achievable if the tobacco control community and the Legislature renew their commitment to the most successful and noteworthy public health tobacco control program in history.

The progress made in California in reducing smoking rates has become stagnant because of program cuts, and is in jeopardy. Inflation has eroded the purchasing power of the money provided by the portion of the tobacco tax that funds the Tobacco Control Program since the voters passed Proposition 99 in 1988. At the same time, cigarette companies have continued to increase spending on advertising and promotion, reaching approximately $1.16 billion in 2000 to market and advertise their addictive products in California alone. In FY 2002,

Tobacco Education and Research Oversight Committee, 2002

Bruce Allen, Jr., DrPH
Charles R. Drew University of Medicine and Science

Ronald Arias, MPA
Department of Health and Human Resources, City of Long Beach

Lourdes Baezondé-Garbanati, PhD, MPH, MA
University of Southern California
IPR/Department of Preventive Medicine, Keck School of Medicine
Hispanic/Latino Network

Stella Aguinaga Bialous, RN, MScN, DrPH
Public Health Consultant
San Francisco

Theresa Boschert, JD
BREATH, The California Smoke-Free Bars, Workplaces and Communities Program
American Lung Association, East Bay

Gregory Franklin, MHA
California Department of Health Services
Health Information and Strategic Planning

Alan Henderson, DrPH
California State University, Long Beach
Health Science Department

Susanne Hildebrand-Zanki, PhD
University of California, San Francisco
Immune Tolerance Network

Kirk Kleinschmidt, Chair
American Heart Association
Western States Affiliate

Rod Lew, MPH
Asian Pacific Partners for Empowerment and Leadership

Cheryl Raney
Sacramento County Office of Education

Dorothy P. Rice
University of California, San Francisco
Institute for Health and Aging

the budget for the Tobacco Control Program was cut by 30%, totaling $46 million. In addition, all future payments from the 1998 multi-state tobacco settlement (Master Settlement Agreement) to California are in effect gone, due to the decision to issue bonds for a one-time lump sum payment to cover the state's FY 2002-2003 budget deficit. This source of funding that was fought for so hard is now unavailable for any health program.

A study published in the *New England Journal of Medicine* (Fichtenberg and Glantz 2000) showed that an estimated 58,900 heart disease deaths were prevented during the first 9 years of the California Tobacco Control Program. The study also noted the human price when the program is cut back and watered down: 15,000 lives were lost from heart disease and stroke alone due to inadequate program funding. While these are not financial costs, they are costs California cannot afford.

We recognize that the budget deficit the State now faces is daunting. But so, too, is the cost of smoking in both dollars and human suffering. In 1999, cigarette smoking cost Californians $15.8 billion — including $8.6 billion in direct medical costs for that year, and costs are rising annually. An investment in tobacco control will immediately begin preventing the premature death of hundreds of thousands of people and save three dollars for every dollar invested. Yet California is spending less to reduce tobacco use while the tobacco companies are increasing their spending to promote it. In 1989, the Tobacco Control Program was funded at only 40% of tobacco industry expenditures on advertising and promotion in California; in 2000, that ratio had dropped to 12%.

We invite the Legislature to hold hearings on our recommendations and urge policy makers to implement them. The result will be thousands of lives saved, now and in the future. We must resist complacency and the notion that the fight against the tobacco companies has been won, and continue to work towards a tobacco-free California.

Kirk Kleinschmidt, Chair
January 2003

Acknowledgements

TEROC would like to thank the many individuals and groups who are committed to tobacco control in California and who contributed to this Master Plan, in particular:

- The local programs in schools and communities throughout California, without which the Tobacco Control Program would not exist;
- Over 200 members of the tobacco control community who attended and spoke at community forums in Redding, Sacramento, San Francisco, Fresno, Los Angeles, and San Diego to provide input to the Master Plan, and sent letters if they could not attend a forum;
- Jon Lloyd, Greg Oliva, and Bill Ruppert, California Department of Health Services, Tobacco Control Section, and others in the Tobacco Control Section;
- Meredith Rolfe, California Department of Education, California Healthy Kids Program, and others on her staff who work on Tobacco Use Prevention Education;
- Charles L. Gruder and others from the University of California's Tobacco Related Disease Research Program;
- Jennifer Ibrahim, Center for Tobacco Control Research and Education, University of California, San Francisco, who provided analyses of tobacco industry and tobacco control program budgets; and
- Lisa K. Hunter and Joy Osterhout, Health & Education Communication Consultants, Berkeley, who served as consultants to TEROC and drafted this Plan.

Contents

Foreword i

Acknowledgements iii

Executive Summary 1

Vision for Tobacco Control in California 5

Victory for Tobacco Control: Reality or Myth? 7

Victory as Reality 7

Victory as Myth 10

Toward a Tobacco-Free California: Objectives and Recommended Strategies, 2003-2005 15

Progress Toward TEROC's 2000-2002 Master Plan

TEROC's 2000-2002 Recommendations 23

Consumption and Prevalence 35

Health Benefits of Cessation 39

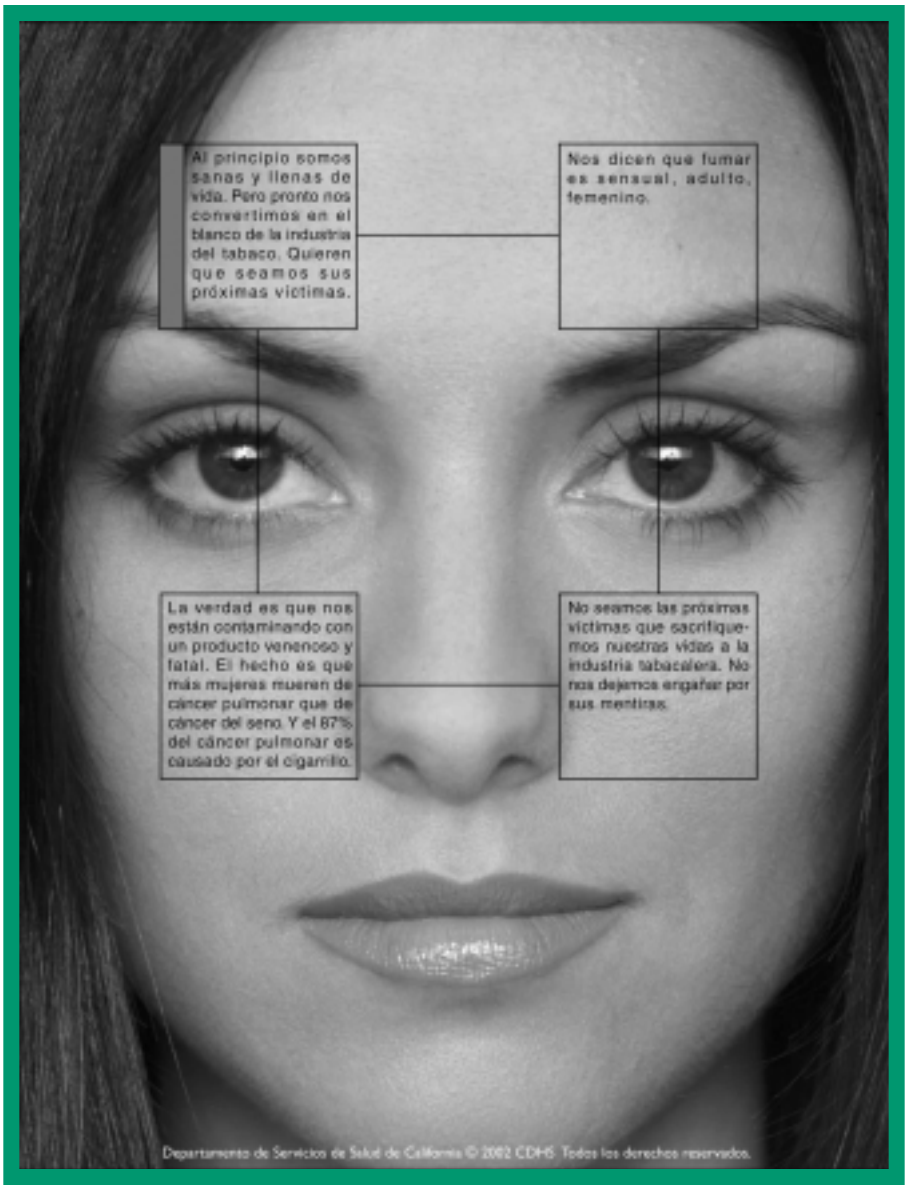
Secondhand Smoke 41

References 43

Appendix

History and Background of the California Tobacco Control Program 45

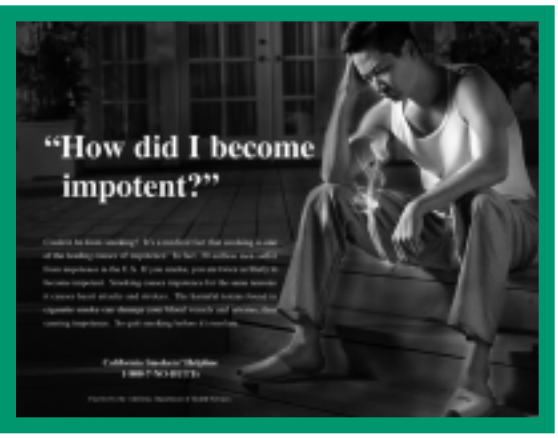
Tobacco Education and Research Oversight Committee 47


Al principio somos sanas y llenas de vida. Pero pronto nos convertimos en el blanco de la industria del tabaco. Quieren que seamos sus próximas víctimas.
Nos dicen que fumar es sensual, adulto, femenino.
La verdad es que nos están contaminando con un producto venenoso y fatal. El hecho es que más mujeres mueren de cáncer pulmonar que de cáncer del seno. Y el 87% del cáncer pulmonar es causado por el cigarrillo.
No seamos las próximas víctimas que sacrifiquemos nuestras vidas a la industria tabacalera. No nos dejemos engañar por sus mentiras.
Departamento de Servicios de Salud de California © 2002 CDHS. Todos los derechos reservados.

Executive Summary

Fourteen years after the passage of Proposition 99 (the Tobacco Tax and Health Protection Act of 1988), the Tobacco Education and Research Oversight Committee (TEROC) presents its sixth three-year Master Plan in accordance with its legislative charge (California Health and Safety Code Section 104350-104480). This Master Plan sets forth policy and budgetary objectives for the next three years in the context of the current environment for tobacco control, and highlights the accomplishments of California's Tobacco Control Program in the last three years.

The status of tobacco control in California is mixed. On the positive side, the state legislature passed several tobacco control bills during the last session, local jurisdictions adopted new tobacco control policies, major businesses have divested retirement funds of tobacco investments, juries and courts are holding the tobacco companies accountable for their words and actions, and there is strong public support for smoke-free environments and increased taxes on tobacco products. California implemented the smoke-free bar provision of AB 13 and the voters passed the Proposition 10 initiative (both in 1998).



However, there are many other factors that have undermined the effectiveness of the Tobacco Control Program. Most tobacco control legislation passed since 1995 has not had a high impact on tobacco use in California and, in particular, has failed to substantially strengthen regulation of the tobacco industry. Moreover, since 1995 the media campaign has lost its bite and is no longer considered the premier tobacco control media campaign in the country.

Neglect of the impact of inflation over time has eroded the program's funding base. Moreover, in response to the FY 2003 State budget deficit, the tobacco control budget was cut by $46 million. At the same time, the tobacco industry continues to increase its expenditures in California on promotion and advertising, totaling $1.16 billion in 2000. While the Tobacco Control Program was initially funded at only 40% of tobacco industry expenditures on advertising and promotion in California, that ratio had dropped to 12% by 2000. As a result, the cost of smoking to California, both in terms of health care and lost productivity, is increasing while the tobacco industry is creating new ways in which to appeal to youth and young adults.

The most important lesson of California's early experience with tobacco control is that it is possible to rapidly reduce tobacco consumption despite the tobacco industry's aggressive and lavishly funded marketing and promotion of their products. Since the passage of Proposition 99 in 1988, cigarette consumption and smoking prevalence have declined, secondhand smoke exposure has decreased, and health benefits have accrued. The Program has been successful, but has become stagnant of late. A tobacco-free California is far from accomplished.

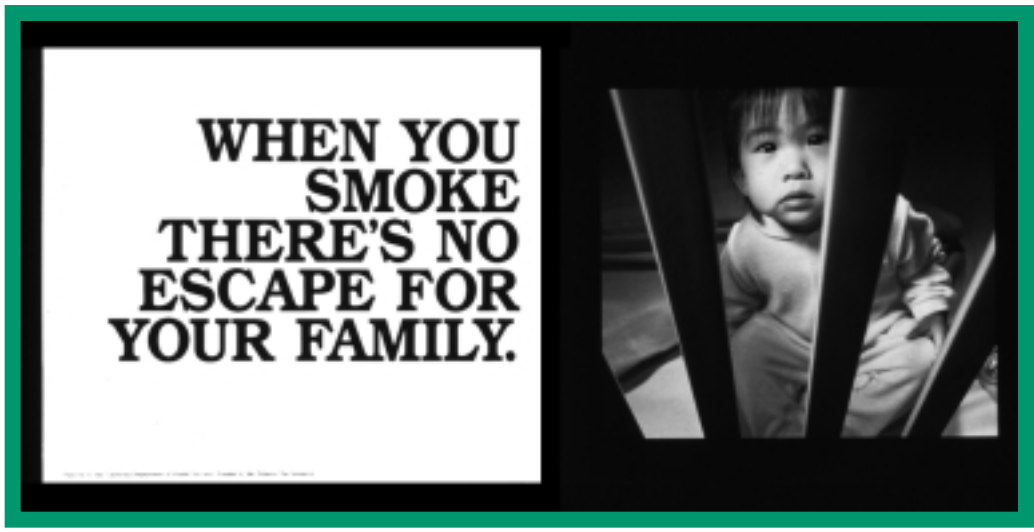
TEROC's Objectives, 2003-2005

The long-term goal for TEROC and other California tobacco control constituencies is to reduce adult smoking prevalence in California to 10% and youth prevalence to 2% by 2007. TEROC's intermediate goal in this Master Plan is to reduce adult smoking prevalence in California to 13% and youth prevalence to 4% by the end of 2005. To achieve its short-term goal, TEROC has six objectives to be pursued over the next three years.

OBJECTIVE 1.
Strengthen the fundamental structure of the California Tobacco Control Program.

While positive change has been made in 11 years, the Tobacco Control Program in California is not at the same level of effectiveness as was seen in the first four years of the program, when annual adult smoking rates decreased from 21.7% to 19.1% of the population. TEROC recommends that steps be taken to return the Tobacco Control Program to its size in real terms in the early 1990s when it was known as the most successful tobacco control program in the nation. To achieve this goal as well as to return to a reasonable level of competitiveness with the tobacco industry, TEROC recommends that the budget for the Tobacco Control Program be increased by $194 million to a total of $301 million for FY 2003-2004. While this seems like a large investment for California, it is not. Such action would result in savings, both short term (reduction in the number of heart attacks, stroke and low birth weight babies) and long term (reduction in cancer and lung disease), in the improvement of health of the people and reduced medical costs. In financial terms, the resultant savings would be three to eight times the investment.

Along with the investment of dollars, there must also be a serious commitment to creating progressive legislation that restricts the tobacco industry's marketing, and a vigorous, attention-getting media campaign.



OBJECTIVE 2.
Increase the price of tobacco products.

TEROC recommends that the price of tobacco products be increased through an increase in the excise tax or other means, such as a mitigation fee. The price of tobacco products should be at a level commensurate with their cost to society, currently pegged at $11.34 per pack of cigarettes (Max et al. 2002).

TEROC further recommends that, when the price of tobacco products is increased, at least 20 cents per pack of any tobacco tax increase be earmarked for tobacco control and that this rate should be indexed to inflation. These additional revenues are needed to offset the dramatic declines in Proposition 99 tobacco tax revenues and the recent budget cuts. The history of the Program shows a clear dose response between Tobacco Control Program funding and reductions in the rates of smoking in California. If Program funding is cut, impact is reduced. Research has shown that an important way to reduce smoking is to increase the price of tobacco (Chaloupka and Pacula 2001).

OBJECTIVE 3.
Work toward eliminating disparities and achieving parity in all aspects of tobacco control.

Tobacco-related disparities still exist for communities of color (African Americans, Asian Americans and Pacific Islanders (AAPIs), Hispanic/Latinos and Native Americans) and other priority populations (low socioeconomic status; lesbian, gay, bisexual, transgender (LGBT); women; rural communities; school-aged youth, and young adults 18-24).

For example, African Americans have the highest lung cancer incidence and mortality rates of the four major ethnic population groups. American Indians and specific AAPI subgroups have some of the highest prevalence of smoking, and Hispanic/Latinos are the least protected group in terms of secondhand smoke in the workplace. Some of these disparities are related to tobacco industry targeting. There are also historic inequities in resource allocation, capacity building and program infrastructures, and representation and involvement in policy and decision-making processes. As new populations of

immigrants come into California, efforts to change cultural norms must be expanded even further to address disparities in tobacco prevention and cessation research, programs and services.

OBJECTIVE 4.
Decrease exposure to secondhand smoke.

Secondhand tobacco smoke contains carcinogens for which there is no safe level of exposure, and is a leading cause of preventable death in California. Nobody should be involuntarily exposed to secondhand smoke where they work, live, or play. TEROC recommends that California maintain and expand its smoke-free workplace protections; increase enforcement of public policies promoting smoke-free environments; and implement a campaign for smoke-free shared spaces, including all indoor and outdoor public spaces and common areas of multi-unit residential housing. Further, TEROC recommends the development and implementation of local policies, both voluntary and mandatory, to reduce and eliminate exposure to drifting secondhand smoke everywhere.

OBJECTIVE 5.
Increase availability of cessation assistance.

Tobacco use cessation is a desired outcome of all initiatives and activities of the Tobacco Control Program, and all tobacco users (including smokeless tobacco users) should have access to culturally and linguistically appropriate cessation assistance. For this to occur, changes are necessary in the health care environment. TEROC recommends that there be a new funding source for dedicated cessation services, such as the proposed mitigation fee (see Objective 2, page 18), and that health care providers — including Medi-Cal — should offer smoking cessation treatment as a covered core benefit.

OBJECTIVE 6.
Initiate efforts to regulate the tobacco industry and its influence.

The tobacco industry is still aggressively marketing products known to be addictive and cause the premature death of tens of thousands of Californians and hundreds of thousands of Americans each year. Given the staggering impact it is having on the public's health, TEROC recommends that state as well as local governments in California strictly regulate the tobacco industry at every level of its operation, from product manufacture to marketing and retail sale. Industry activities must be monitored, and regulatory action must be taken to eliminate messages and tactics aimed at recruiting new smokers and perpetuating the addiction of current tobacco users. TEROC commends Attorney General Bill Lockyer for actively and aggressively enforcing provisions of the Master Settlement Agreement and calls upon the California Legislature to enact legislation that will further regulate the tobacco industry.

Accomplishments of the Tobacco Control Program

Despite the current budget challenges, it is important to recognize the success enjoyed in the past few years and to move forward with a renewed commitment to defeating the tobacco industry's detrimental business practices. Highlights of the accomplishments of the Tobacco Control Program include reductions in smoking prevalence, tobacco consumption, and secondhand smoke exposure, and the corollary health benefits of these reductions. The California Tobacco Control Program saves money.

- Adult smoking prevalence in California has dropped by about 25% (from 22.8% in 1988 to 17.4% in 2001)[1], at a rate faster than the nation. Most of this drop, however, occurred in the first 6 years of the program when it was larger and more aggressive than it is now. Smoking prevalence in 2000 translates to about 4.2 million smokers in California.
- While prevalence has remained flat since 1997, smokers have continued to reduce their consumption, a notable success. In 1999, 60% of California smokers were smoking fewer than 15 cigarettes a day. These light smokers are more susceptible to efforts to encourage them to quit and represent an important opportunity to reinvigorate the tobacco control program.

[1] *Data for adult smoking behavior come from the California Adult Tobacco Survey (CATS), conducted annually since 1994 by the Cancer Surveillance Section of the DHS; and the California Tobacco Survey (CTS), conducted in 1990, 1992, 1993, 1996, and 1999 by the University of California, San Diego. These surveys are conducted with random samples of households through computer assisted telephone household interviews. CATS has a sample of 4,000 adults per year; CTS has 78,000 adults in each survey.*

- Youth smoking prevalence fell to 5.9% in 2001, from 11% in 1994 (the first year an annual prevalence estimate was provided by the California Youth Tobacco Survey).
- The reduction in tobacco consumption has led to immediate health benefits for the California population. For example, smoking cessation produces almost immediate reductions in heart attacks and strokes (Lightwood and Glantz 1997) and low birth weight infants (Lightwood, Phibbs, and Glantz 1999). The impact of the California Tobacco Control Program resulted in 33,000 fewer deaths from heart disease between 1989 and 1997 than would have been expected without the program (Fichtenberg and Glantz 2000). Lung and bronchus cancer rates in California declined 14.4% between 1988 and 1996, compared with only a 4% decrease in other Surveillance, Epidemiology, End Results (SEER) regions[2]. While women in California experienced a **decrease** in lung cancer incidence of 6.7%, women in other SEER regions experienced an increase of 9.3%.

TEROC asks the Legislature to hold hearings on the recommendations in this Master Plan, and urges policy makers to implement them. The result will be thousands of lives saved. We must resist complacency and the notion that the fight against the tobacco companies has been won. We must continue to work towards a tobacco-free California.

[2] *Surveillance, Epidemiology, End Results (SEER) registries in Connecticut, Detroit, Hawaii, Iowa, New Mexico, Seattle, Utah, and Atlanta were compared with the California Cancer Registry for this analysis.*

Vision for Tobacco Control in California

In November 1988, California voters approved the historic ballot initiative called Proposition 99 that increased the tax on each pack of cigarettes sold in California by 25 cents, effective January 1, 1989. Since then, the State's annual per capita rate of cigarette consumption has declined by over 50 percent. Smoking prevalence declined in adults from 22.8% in 1988 to 17.4% in 2001, and in youth from 11% in 1994 to 5.9% in 2001 (California Department of Health Services 2001). But there are still approximately 4.2 million adult smokers in California, and their secondhand smoke is affecting many nonsmokers.

From its earliest days, the California Tobacco Control Program has worked toward a State free of tobacco in which there are few tobacco-related illnesses and deaths. TEROC and other tobacco control constituencies have set a goal to reduce smoking prevalence to 10% in adults and 2% in youth by 2007. To reduce prevalence to these levels, TEROC's intermediate goal in this Master Plan is for smoking prevalence in California to decrease to 13% in adults and to 4% in youths by 2005.[3]

THE CALIFORNIA TOBACCO CONTROL PROGRAM: PUBLIC HEALTH, EDUCATION, AND RESEARCH

The California Tobacco Control Program was initiated in 1989 after the passage of Proposition 99. Prop 99 increased the tobacco tax by 25 cents per pack, and earmarked funds for tobacco control. The Program has three major components—public health, public education, and research — that together create a comprehensive, coordinated effort to change the social acceptability of tobacco.

The ***Tobacco Control Section (TCS) of the California Department of Health Services (CDHS)*** *administers the public health aspects of the program, including 61 local health departments, four ethnic networks, a statewide media campaign, and over 100 community-based organizations.*

The Healthy Kids Program Office (HKPO) of the California Department of Education (CDE) *is responsible for administering the Tobacco Use Prevention Program in nearly 1,000 school districts, with assistance from 58 county offices of education.*

The Tobacco-Related Disease Research Program (TRDRP) *is administered by the* ***University of California (UC)****. TRDRP funds research that enhances understanding of tobacco use and tobacco-related diseases, and provides more effective interventions for prevention and treatment.*

[3] *When the Legislature passed AB 75 in 1989 to create the Tobacco Control Program, it set a goal of reducing tobacco use in California by 75% (to 6.5%) by the end of 1999.*

Vision
A tobacco-free California.

Mission
To reduce tobacco-related illness and death.

Goal
To reduce smoking prevalence to 13% in adults and 4% in youths by 2005, in order to reach 10% adult prevalence and 2% youth prevalence by 2007.

Because the use of tobacco has steadily declined since the implementation of the Tobacco Control Program in 1989 and policy achievements — such as the smoke-free bar law — are highly visible, some of our leadership has become complacent. There is a growing perception that we have won the battle with Big Tobacco and have less need for tobacco control.

This is the myth of victory. The truth is to the contrary. Despite impressive national, state and local successes in diminishing the credibility and restricting the influence of the tobacco industry, a tobacco-free California will only come about through increased commitment to continue changing the social acceptability of commercial tobacco.

California, which once had the most effective tobacco control program in the world, has lost its position of leadership. It is now 20th in per capita funding among U.S. states, according to the Campaign for Tobacco Free Kids (2002), and does not even reach the minimum levels recommended by the U.S. Centers for Disease Control and Prevention.

We must continue working to eliminate racial and ethnic disparities in tobacco use and its health consequences. In California, eliminating disparities is more critical than ever because racial and ethnic minorities now comprise the majority population. National data from the U.S. Department of Health and Human Services (1998) show that African American men are at least 50% more likely to develop lung cancer than white men, and have a higher mortality rate of cancer of the lung and bronchus than do white men. Cardiovascular disease is the leading cause of death, and lung cancer the leading cause of cancer deaths among American Indians and Alaska Natives. Recent immigrants to the United States are also more likely to use tobacco than their acculturated peers; for example, among Asian American and Pacific Islander adults from Southeast Asia, those with high English-language proficiency and living in the U.S. longer are less likely to be smokers (U.S. Department of Health and Human Services 1998).

Despite what some may believe, the tobacco industry has not given up the fight; rather it has attempted to change its image, furthering the illusion of a victory. It is increasingly aggressive in targeting young adults, communities of color, and other priority populations. Contrary to its public relations campaigns, it has not transformed itself into a benevolent community patron. The industry may have signed an agreement to stop marketing its products to youth, but its advertising and promotions are still designed to appeal to them.

Gone are the cartoon characters that proved wildly successful in marketing tobacco to youths. In their place are more confusing and sophisticated campaigns, ostensibly designed to reduce the level of direct marketing to adolescents. They nonetheless retain the cunning ability to attract young consumers through deliberate manipulation of antismoking messages.

(Ellis 2002)

To reduce smoking prevalence and tobacco use, California's Tobacco Control Program must continue its comprehensive and integrated approach, which includes exposing the industry's changing covert strategies, and researching, developing, and implementing evidence-based programs and policies. The Program must counter any impression that funding for tobacco control is bountiful and guaranteed, and that the Master Settlement Agreement has rendered the industry weak. The numerous agencies working toward reducing smoking prevalence must continue to collaborate and coordinate their efforts to the greatest possible extent.

This Master Plan acknowledges the progress that California has made toward a tobacco-free state, and demonstrates that full victory over tobacco is a myth that threatens to drain resources and momentum. We must maintain energy and vigilance if our goal is to be reached.

Victory for Tobacco Control: Reality or Myth?

The 1998 Master Settlement Agreement (MSA) between the tobacco industry and 46 state attorneys general awarded $206 billion through the year 2025 to the states and somewhat restricted the industry's advertising scope. Even though the revenues generated from this settlement were not restricted to use for tobacco control programs, such a settlement was unprecedented and unimaginable even three years earlier. Since then, the tobacco industry has lost several large lawsuits brought against them by individuals suffering from tobacco-related diseases. The mood of the general public is decidedly anti-tobacco.

However, this mood is not reflected in the political climate or in the budgets of tobacco control programs. Alarmingly few states have used their tobacco settlement funds to initiate or enhance their tobacco control programs.[4] MSA funds are no longer available to California's Tobacco Control Program. At the same time that tobacco control budgets are being reduced because of inflation and budget cuts, tobacco companies continue to make heavy political campaign contributions; increase real advertising and promotional expenditures targeting youth and young adults through devious marketing strategies designed to promote a positive image of the industry; and market heavily to young adults, ethnic and racial populations, and blue-collar communities.

Consider these facts: Four of five major tobacco companies still question whether smoking causes disease. All five major tobacco companies deny that environmental tobacco smoke causes disease in nonsmokers. Four of five major tobacco companies fail to admit that nicotine is addictive. Philip Morris continues to deny it has control over nicotine. R.J. Reynolds continues to deny it has marketed to children. British American Tobacco continues to deny document destruction.

(U.S. House of Representatives, Minority Staff Report, at the request of Rep. Henry Waxman 2002)

Victory as Reality

There is evidence of significant advances in tobacco control: the proliferation of state and local laws restricting the sale and use of tobacco; court verdicts against the tobacco industry; and popular support for cigarette company accountability, higher tobacco taxes, and increased protections against secondhand smoke. Furthermore, data show that a well-balanced, well-funded comprehensive tobacco prevention program works.

Victory 1. California legislators drafted and passed 10 new state tobacco control laws. Although even stronger legislation is needed to curb tobacco industry influence and to regulate the fundamental mechanisms of tobacco distribution, sale, and marketing in California, these new laws represent a definite victory for tobacco control. They are designed to protect young children from secondhand smoke and tobacco litter, and to limit youth access to tobacco products. Table 1 provides a summary of each law at a glance.

[4] *According to the New England Journal of Medicine (Gross et al. 2002), in 2001 the average state received $28.35 per capita from the tobacco settlement but allocated only 6% of these funds to tobacco control programs. Although the need to recover smoking-attributable medical expenditures provided a rationale for the lawsuits that led to the settlement, over one-third of the settlement funds were allocated to non-health-related programs.*

TABLE 1
Recent Tobacco Control Legislation

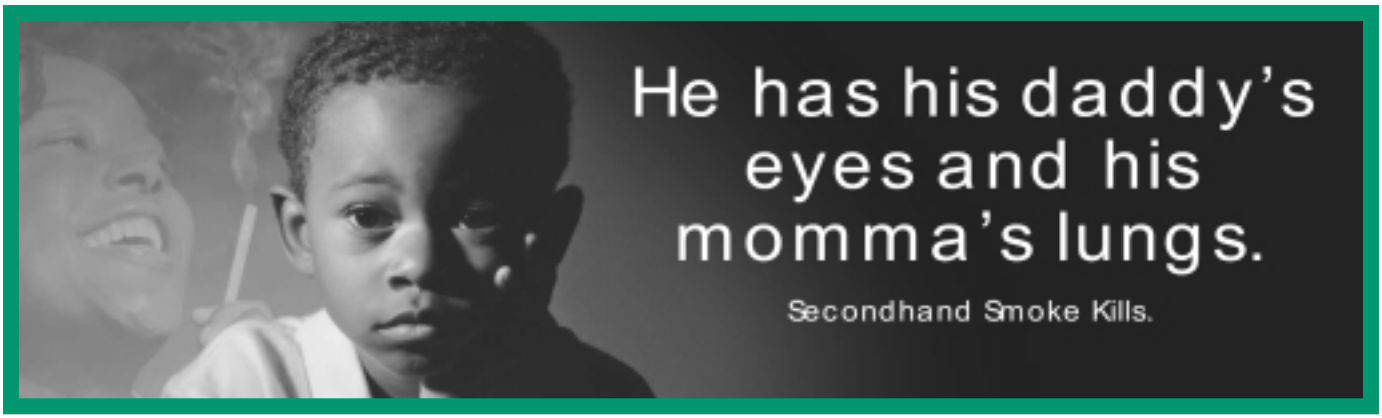
Name of Law	Code/Author	Description	Effective
Smoking in Playgrounds or Tot Lots	HSC 104495/Vargas	Prohibits smoking of tobacco products and disposal of tobacco-related waste within a playground or tot lot sandbox area. Amended in 2002 to prohibit smoking within 25 feet of playground/tot lot; increase fine from $100 to $250.	1/1/02 1/1/03
Tobacco Sales to Minors	BP 22950-22962/Ortiz	Tightens existing laws on tobacco sales to minors and the STAKE Act; expands authority of CDHS to conduct investigations of tobacco sales to minors via phone, mail, internet.	1/1/02
Self-Service Cigarette Sales	BP 22962/Ortiz	Prohibits sale or display of cigarettes through self-service display.	1/1/02
Sale of Bidis	PC 308.1/Ortiz	Prohibits sale, distribution, importation of bidis except at businesses that prohibit the presence of minors.	1/1/02
Distribution of Tobacco Product Samples and Coupons	HSC 118950/Ortiz	Expands law prohibiting distribution of tobacco product samples and coupons on public grounds to private grounds open to the public (e.g., race tracks, retail outlets).	1/1/02
Minimum Pack Size	PC 308.3/Ortiz	Prohibits manufacture, distribution, sales of packages of less than 20 cigarettes.	1/1/02
Mail Order Tobacco Sales	BP 22963/ Frommer	Prohibits distribution or sale of tobacco products to minors via public or private postal services; includes directives to ensure that those who order are 18 years or older.	1/1/03
Black Market Cigarette Sales	R&T 30474/ Koretz	Adds an extra $100 penalty to existing penalty for each carton of cigarettes knowingly held or offered for sale or sold without a tax stamp or meter impression.	1/1/03
Mail Order Cigarette Taxation	R&T 30101.7/ Ortiz	Requires those selling cigarettes via internet or telephone to pay all applicable California tax or include warning that buyer is responsible for unpaid state taxes.	1/1/03
Tax Stamps	R&T 30162.1 / Peace	Requires Board of Equalization to replace cigarette tax stamps and meter impressions with a stamp or meter impression that can be read by scanner.	1/1/05

Victory 2. Local California jurisdictions adopted 63 tobacco control policies between July 1999 and June 2002. These policies restrict youth access to tobacco by requiring tobacco retail establishments to be licensed; create zoning limitations where tobacco-only stores can open; eliminate self-service displays of tobacco products; and create smoke-free zones in outdoor dining facilities and around doorways. The California Smoke-Free Workplace Act (Labor Code 6404.5) that prohibits smoking in the workplace — including bars — is now enforced by local agencies throughout the state, with technical assistance from BREATH[5], the California Smoke-Free Bars, Workplaces and Communities Program.

Victory 3. A movement to divest retirement funds of tobacco investments gained momentum. In 2000 (with technical assistance from the Prop 99-funded Council for Responsible Public Investment and the Technical Assistance Legal Center), the California Public Employees' Retirement System (CalPERS) and the California State Teachers' Retirement System (CalSTRS) divested of international and domestic tobacco stocks. In addition, the University of California Board of Regents and the California Pooled Money Investment Account (PMIA) placed a moratorium on tobacco investments. Between 1998 and 2000, 2 counties and 7 cities in California also divested their jurisdictions' retirement accounts of tobacco investments.

Victory 4. Federal regulation of tobacco has bipartisan support. In the summer of 2002, Senators Kennedy (D-MA) and DeWine (R-OH) introduced the Youth Smoking Prevention and Public Health Act that would give the U.S. Food and Drug Administration (FDA) authority to regulate tobacco products. The Act would grant the FDA regulating authority over the sale, distribution, access, advertising and promotion of tobacco; force tobacco companies to disclose all health information regarding tobacco; allow the FDA to revise health warnings on tobacco products; give the FDA authority to disseminate performance standards for tobacco; and allow state and local governments to regulate access, advertising and promotion of tobacco. Although the bill did not pass during the 2002 legislative session, it was one of multiple such efforts in Congress (HR 1043 and HR 1097 were introduced in the House). Of the 52 Members of Congress from California in 2002, 25 co-sponsored at least one of these bills.[6]

Victory 5. Juries and courts are holding tobacco companies accountable. In August 2002, the California Supreme Court ruled that the tobacco industry was no longer protected from litigation for their actions, except for actions between 1988 through 1997[7]. Increased understanding of the actions of



[5] *BREATH, the California Smoke-Free Bars, Workplaces and Communities Program, is a statewide, Proposition 99-funded grantee sponsored by the American Lung Association of the East Bay. BREATH works on implementing and expanding state and local legislative protections from exposure to secondhand smoke, indoors and outdoors.*

[6] *Matsui, Woolsey, G. Miller, Pelosi, Lee, Tauscher, Lantos, Stark, Eshoo, Farr, Capps, Gallegly, Sherman, McKeon, Berman, Waxman (primary sponsor), Watson, Roybal-Allard, Napolitano, Harman, Millender, McDonald, Horn, Bono, Davis, Filner.*

[7] *In 1988 the California Legislature passed a statute—California Civil Code 1714.45, also called the "Napkin Deal"—that barred claims against tobacco or other products whose risks were allegedly well known. The law was repealed in 1997, but is under appeal by the tobacco industry to the California Supreme Court.*

the tobacco industry is also evident in other states: in 2001 and 2002, juries in Florida, Oregon, Kansas, and Puerto Rico awarded large damages to individuals suffering from cancer and other tobacco-related diseases. An award by a Los Angeles jury in October 2002 in *Bullock v. Philip Morris* was a record for an individual—$28 billion for punitive damages. (The case is under appeal at writing.)

Victory 6. The general public is highly supportive of public and private smoke-free environments and of increasing the tax on tobacco products. A Field Poll survey of California bar patrons in October 2000 showed increased support for smoke-free bars over previous years. Seventy-five percent said they preferred smoke-free environments in bars, compared with 68% who answered this way in 1998; 87% of bar patrons reported they were "as likely" or "more likely" to visit bars since they had become smoke-free. Among smokers, support for the law has almost doubled since 1998 (from 24% to 44%). Another Field Poll in January 2001 of 1812 adults found high support for smoke-free environments that are not currently regulated by state law (such as building entrances, outdoor dining areas, nursing homes, casinos, apartment units).

Interviews with California adults conducted in 1996 and 1999 showed strong support for additional cigarette taxes. Proposition 10 increased the price of cigarettes by 50 cents per pack in 1999. This increase did not diminish Californian's overwhelming support for an additional cigarette excise tax. In 1999, nearly 70% of all respondents on the California Tobacco Survey supported a tax increase of at least 25 cents per pack, and nearly 50% supported an increase of at least $1 per pack (Gilpin et al. 2001).

Victory 7. The Tobacco Control Program has had an impact on adult smoking prevalence. According to the independent evaluation of the California Tobacco Control Program, counties where residents had more exposure to multiple components (the media campaign, community programs, and school-based programs) had greater changes in tobacco-related attitudes and behaviors, including lower adult smoking prevalence, than counties where program exposure was less (Independent Evaluation Consortium 2001).

Victory as Myth

Despite the very real progress that has been made in tobacco control, there are many reasons for TEROC's conclusion that the victory over tobacco is a myth. National economic trends together with widespread industry marketing strategies have set the stage for an ill-advised retreat in government support for tobacco control efforts. Funding for tobacco control is as important now as it was 14 years ago.

Myth 1. The budget for the California Tobacco Control Program is sufficient to counter tobacco industry marketing. The fact is that industry marketing budgets are vastly greater than funding for tobacco control in California, and industry spending has increased dramatically since the MSA went into effect in 1998. In 2000, the tobacco industry spent approximately $1.16 billion on marketing tobacco products in California, when the total budget for the California Tobacco Control Program (including the media campaign, local health programs, local schools, and the research program) was $134.5 million, a mere one-tenth of the tobacco industry budget.

The gap in spending will continue to widen. Real Prop 99 funding for tobacco control is decreasing as inflation has eroded the purchasing power of the money since the initiative passed in 1988 and consumption drops. To make matters worse, funds for the Program were further reduced by a $46 million budget cut for fiscal year 2002-2003. At the same time, the tobacco industry has continued to increase its promotional spending.

Figure 1 shows the great and increasing discrepancy between tobacco industry and tobacco control spending in constant (inflation-adjusted to 2002) dollars. More important, Figure 2 shows that the California Tobacco Control Program is only spending 12% of what the tobacco industry is spending, down from about 25% during the early years of the program, when it was achieving rapid reductions in smoking. There is no reason why California could not achieve a similar level of progress if the Program were restored to its early level of competitiveness with the tobacco industry.

Myth 2. The Master Settlement Agreement (MSA) has greatly increased funds for tobacco control. Nationally, many states are "raiding" tobacco MSA funds to shore up their general fund deficits at the expense of tobacco control programs. The U.S. Centers for Disease Control and Prevention (CDC) recommends that 20% to 25% of each state's tobacco settlement funds go toward tobacco prevention (Gross et al. 2002). A July 2002 report (Campaign for Tobacco Free Kids 2002) showed that only three states were meeting minimum spending levels recommended by CDC for tobacco

prevention programs. California is not one of these states.

California is expected to receive a total of $21.3 billion over the next 23 years from the tobacco companies through the MSA. This amount seems large until it is compared to the $15.8 billion annual cost of smoking in California (Max et al. 2002). This potential source of future Tobacco Control Program funding was eliminated in 2002 when the State mortgaged all of its future settlement payments to cover the State's 2002-2003 budget shortfall. In only one year (FY 2001-2002) did any of the State's share of MSA revenues go toward tobacco control, and this was only $20 million of $25 billion.

One can hardly blame the governor for going after that money. These are hard times in Sacramento and many other worthy programs are getting hit. But with tobacco industry advertising at record levels, and the State cutting back its efforts, it does tilt the odds further against critical efforts to reduce teen smoking.

(San Diego Union-Tribune Editorial, June 14, 2002)

Figure 1

Comparison of Tobacco Control (TC) Expenditures and Tobacco Industry (TI) Expenditures in California (in 2002 dollars)

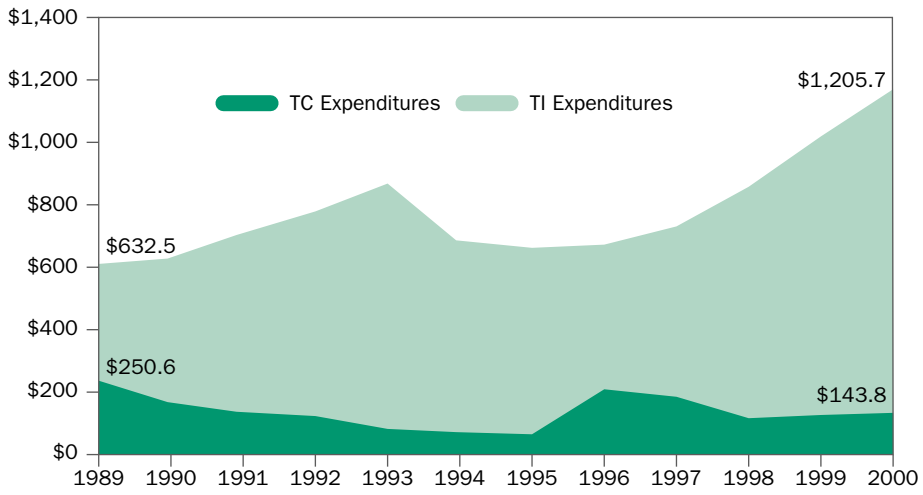
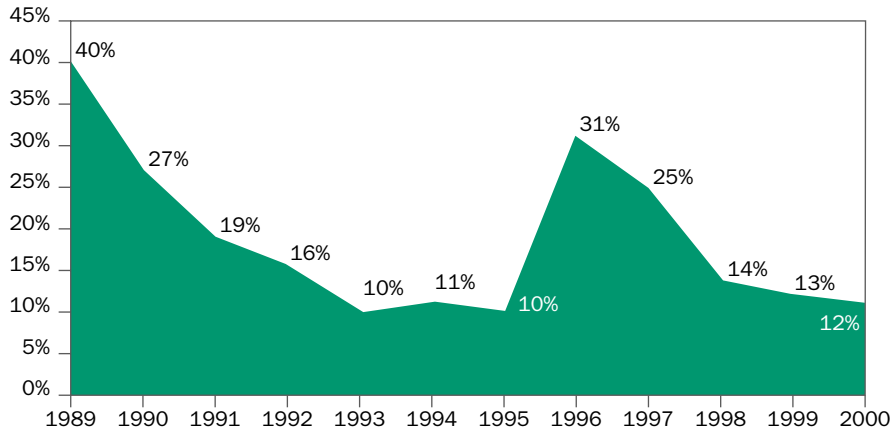


Figure 2

Ratio of Tobacco Control Expenditures to Tobacco Industry Expenditures in California



Myth 3. The costs of smoking to California are decreasing. The fact is that costs have doubled in the last ten years. In 1989, the economic burden of smoking in California — including health care costs and lost productivity — was $7.6 billion. In 1999, the cost was $15.8 billion — $475 per Californian and $3,331 per smoker. This includes increased direct health care costs ($8.6 billion), lost productivity due to illness ($1.5 billion), and lost productivity from premature death ($5.7 billion) (Max et al. 2002). If smokers paid for smoking-related health care costs, the cost per pack of cigarettes would increase by $6.16. If they also paid for indirect productivity losses, the cost per pack would increase by an additional $5.18. The total medical care costs and productivity losses to society is $11.34 per pack of cigarettes (Max et al. 2002).

UNFORGIVABLE

MAN:
Father, I've come to confess that I have done terrible things...

PRIEST:
I'm listening; what have you done?

MAN:
Day after day, I continue harming people.

PRIEST:
In what way?

MAN:
Because of me, hundreds of thousands of people die every year. I'm a bad influence on children, I manipulate them and make them sick with bronchitis, asthma, and other terrible diseases. Because of me, families are torn apart. I work my way into their lives and cause them great pain.

VOICE OVER:
After all the destruction the tobacco industry continues to cause, now they are trying to win public approval, sponsoring activities and events in our communities. The truth is, the tobacco companies continue to encourage people to smoke, making a product that causes many diseases and kills hundreds of thousands every year.

And that...is unforgivable.

("Unforgivable" Radio Ad, 2002 Statewide Media Campaign)

Myth 4. It takes decades for the Tobacco Control Program to affect health or health care costs. While some diseases (notably cancer) respond slowly to changes in smoking, others, such as heart disease, stroke and low birth weight infants, respond quickly. The rapid reductions in smoking reduced these diseases substantially in the same year as the program expenditures. At the same time, reductions to the program mean immediate illness and deaths.

Myth 5. States can limit tobacco advertising. This was proved a myth in 2001, when a ruling by the U.S. Supreme Court preempted many local policies in California *(Lorillard Tobacco Co. v. Reilly).* The Court struck down a Massachusetts regulation that limited tobacco advertising inside and outside of retail outlets within 1,000 feet of schools and playgrounds, stating that the Federal Cigarette Labeling and Advertising Act preempted state regulation. This decision was a giant step backward for the California jurisdictions that had already enacted local tobacco advertising ordinances. They were forced to suspend the enforcement of their ordinances and rethink how to address the ubiquitous tobacco advertising that now dominates the retail environment.

Myth 6. Our youth are now protected from the tobacco industry's appeals. The industry has evolved complicated strategies for making tobacco appealing to youth. Among these are:

- Point-of-purchase advertisements, especially in convenience stores where most youth shop (one study showed that 45.2% of all tobacco retail stores had inside ads less than 3 feet above the floor — at a child's eye level) (Gilpin et al. 2001);
- Web sites that sell cigarettes without adequate ID checks for age (Ribisl, Kim & Williams 2002);
- Promotional items from the tobacco industry to adolescents who state they are willing to use such an item if they had one (Gilpin et al. 2001).

San Diego Superior court Judge Ronald S.Prager... imposed a $20 million fine on R.J. Reynolds Tobacco Co.... Prager found that, by advertising in magazines such as InStyle, Spin, Hot Rod, Sports Illustrated and Rolling Stone, Reynolds had violated the historic l998 agreement between the tobacco industry and 46 states that bars the companies from taking 'any action, directly or indirectly, to target youth.'

(San Diego Union-Tribune Editorial, June 14, 2002)

Myth 7. The tobacco industry discourages young people from smoking. Several efforts by tobacco companies are trying to gain public favor by disseminating so-called anti-tobacco messages to youth. In fact, current research shows that these programs are based on principles that have been proven to be ineffective with youth, and stress themes that offer benefits to the tobacco industry (such as "wait until you're older

to smoke"). Furthermore, industry-sponsored programs were found to have no effect or to have the opposite effect. For example, the Philip Morris anti-smoking campaign ("Think. Don't Smoke") appears to move youths' attitudes in a pro-tobacco direction rather than discouraging them from smoking (Farrelly and Davis 2002).

Industry funding and distribution to schools and youth organizations of youth smoking prevention programs that are not effective in decreasing youth smoking also supplants the use of programs that are effective (Landman, Ling and Glantz 2002). Many health organizations have recently called for the industry to cease and desist with these efforts.

Myth 8. The tobacco industry's marketing abroad is not related to smoking in the United States. In response to the unfriendly tobacco environment in the U.S., as well as the general trend of globalization, the tobacco industry has placed more emphasis on marketing its products in less developed countries. This has increased the need for tobacco control advocates to address transnational tobacco issues, especially as they impact new arrivals to the U.S. In California, foreign-born individuals now account for approximately 25% of the State's population, and many have emigrated from countries where heavy tobacco use is the norm. New tobacco prevention, education and research strategies in California must be developed for this segment of the population. California must continue to lead in the movement to make tobacco companies accountable for their role in the global tobacco epidemic.

Myth 9. The tobacco industry does not interfere with public health groups, health departments, or prevention initiatives. A recent study provides examples of aggressive tobacco industry surveillance of tobacco control efforts that obstruct or delay initiatives. These tactics included attendance at meetings, use of intermediaries to obtain organizations' printed materials under false pretenses, use of public relations specialists as spies, covert audio taping of meetings that violate state laws and codes of ethics, and maintenance of detailed lists of industry critics (Malone 2002).

Myth 10. Only the villains smoke in films. In the 1990s, 9 out of 10 Hollywood films dramatized the use of tobacco; 28% of the films — including one in five children's movies — showed cigarette brand logos. In these films, appealing action figures as well as the villains are smoking. For example, the comic book-based blockbusters *Men in Black* (1997) and *Men in Black II* (2002) both feature Marlboros, the leading teen cigarette. Non-smoking teens whose favorite stars frequently smoke on screen are sixteen times more likely to have positive attitudes towards smoking in the future. Even more important, 31% of teens who saw more than 150 occurrences of smoking in movies (in theaters, on video, or TV) had tried smoking compared to only 4% among teens who had seen less than 50 occurrences. Even after controlling for the effects of parents smoking and other factors, seeing a lot of smoking in the movies *tripled* the odds that a teen would try smoking (Glantz 2002). The amount of smoking in top-grossing PG-13 movies increased by 50% in the two years following the Master Settlement Agreement compared with the two years before (Ng and Dakake 2002).

Myth 11. The tobacco industry has reformed. Tobacco companies are supporting worthy endeavors such as feeding the hungry, aiding victims of natural disasters, and protecting women who are victims of abuse. They are also publicizing these endeavors and, in fact, spending more money on that publicity than on the good works themselves. In 2000, Philip Morris spent $115 million on various charity programs, and an additional $150 million on a national advertising campaign, boasting about its "charitable aid" (Harris 2001). Such public relations maneuvers are influential, and there are indications that they have influenced many opinion leaders and policy makers, if only by giving them "cover" for helping the tobacco industry.

AMAZING NEW PRODUCT

ANNOUNCER:

You don't have to love Philip Morris to be impressed with its selling skills. Consider its current hundred million dollar advertising campaign to promote...itself.

MOUTH-BREATHER:

Introducing the amazing, all-new tobacco company!

ANNOUNCER:

You can hardly turn on the tube without running into one of those heart-warming little novellas about how the smokefolk help bring food to the hungry, water to the thirsty, sanctuary to the abused and comfort to the afflicted.

MOUTH-BREATHER:

Now, with social consciousness in every pack! It's fascinating, in a spooky sort of way, to watch Philip Morris re-invent itself as our friendly, concerned neighbor while it continues to push the same old addictive, deadly product that will kill 400,000 of us this year. Fortunately, there's a warning label. Let me read it. It says:

If you can't tell the difference between the old Philip Morris Company and the new Philip Morris Company...don't worry...there isn't any!

("Amazing New Product" Radio Ad, 2001 Statewide Media Campaign)

In 2003, while substantial progress has been made, victory over tobacco is a myth. The misperception that the settlement with tobacco companies has taken care of the Tobacco Problem once and for all is what the industry would like us to believe. We still need to help smokers to quit, teach youth about tobacco advocacy, conduct research about tobacco and convince policy-makers to forge effective and protective laws. We are not yet a tobacco free state.

Toward a Tobacco-Free California: Objectives and Recommended Strategies – 2003-2005

To achieve the short-term goal of reducing smoking prevalence to 13% in adults and to 4% in youths by 2005, TEROC has developed six objectives and several recommended strategies to pursue over the next three years to reach each objective.

OBJECTIVE 1. Strengthen the fundamental structure of the California Tobacco Control Program.

The goal of the Tobacco Control Program is to denormalize tobacco use by challenging and changing the social norms regarding tobacco use and tobacco's place in society. Durable social norm change occurs through shifts in the social environment of local communities. The tobacco industry itself concludes that this approach dramatically affects the smoking cessation rate (Wakefield and Chaloupka 2000).

The fundamental structure of the Program includes cooperative efforts of three agencies: The California Department of Health Services, Tobacco Control Section (CDHS/TCS); the California Department of Education, Healthy Kids Program Office (CDE/HKPO); and the University of California, Tobacco Related Disease Research Program (UC/TRDRP). These agencies fund a network of local health departments, schools, county offices of education, researchers, and competitive grantees. (The appendix contains a full description of the Program's history and structure.) During 11 years of tobacco control, collaboration among public health, education and research has increased, although more cooperation is imperative.

The basic structure of the Tobacco Control Program must be energized and strengthened to continue to protect the public's health by making tobacco use unacceptable. To keep the infrastructure strong and effective, funding for the program must be protected. The purchasing power of Prop 99 funding for tobacco control is decreasing because of inflation and dropping consumption, and funds were also reduced by $46 million in the state budget for fiscal year 2002-2003. This reduction included the cutting of $20 million for youth anti-tobacco programs from the Master Settlement Agreement (MSA). At the same time, as shown in Figure 1 (page 11), the amount spent by the tobacco industry for marketing in California is increasing.

California has a budget crisis, but cutting tobacco control funding will aggravate that crisis by increasing medical costs, even in the short run. For every dollar invested in the Tobacco Control Program, $3 is saved in direct health care costs ($8 is saved if indirect costs such as lost productivity are included). The history of the Program shows a clear dose response between Tobacco Control Program funding and reductions in the prevalence of smoking in California. Restoring funds to the Tobacco Control Program — thereby maintaining its effectiveness to fight the pervasive influence of the tobacco industry and assist smokers to quit — will result in a further reduction in the incidence of lung cancer, heart disease, emphysema and other deadly tobacco-related diseases. Decreasing illness and deaths from tobacco-related diseases will significantly lower the economic costs to the state.

Because the main opponent of the Tobacco Control Program is the tobacco industry, future Tobacco Control Program budgets should be competitive with the expenditures by the tobacco industry on promotion and advertising in California. Since the mid-1990's, the gap between the expenditures on tobacco control and tobacco promotion and advertising has been steadily increasing.

Between 1989 and 1993, when the Tobacco Control Program was effectively competing with the tobacco industry, the four-year average allocation of funds for the Program was 25% of the expenditures by the tobacco industry on advertising and promotion. As of 2000, this ratio had dropped to 12%. To return to the same level of competitiveness the Program had with the tobacco industry in the early years, the Tobacco Control Program would have to be funded at 25% of the industry's expenditures, which totaled approximately $1.16 billion in 2000; accounting for inflation, this is equal to about $1.21 billion in 2002.

Therefore, if the tobacco control budget were funded at 25% of the tobacco industry's expenditures on advertising and promotion, the budget would need to be increased to $301.4 million, which is $194 million more than the FY 2002-2003 budget (Table 2). Additionally, Table 2 provides the funding breakdowns for each of the three components of California's tobacco control program based upon the original allocation in the early years of the program.

Since it is TEROC's responsibility to make budget recommendations for the next three years, Table 3 shows the funding necessary to maintain the same ratio of spending with the tobacco industry (25%), accounting for annual inflation. However, it is also important that attention is paid to future spending levels of the tobacco industry, making adjustments to this budget proposal accordingly. Future budgets should continue to account for inflation adjustments, as this was a significant factor contributing to the under-funding of the Tobacco Control Program in the past.

Recommended Strategies for Reaching Objective 1

- Maintain the current structure of the Program. This includes re-establishment of the regional infrastructure and continued collaboration between agencies and programs working for tobacco control.

Medicaid costs [nationwide] attributed to smoking have increased from $12.9 billion in 1993 to $27.2 billion in 2001. States that invest money in tobacco prevention programs can save about $500 million per year in Medicaid costs. "At a time when most states are facing budget shortfalls, state legislators need to understand the enormous benefit of investing in prevention programs. Rather than diverting money for short-term budget fixes, states would be wise to use the money to reduce the long-term budgetary impact of tobacco use. Tobacco prevention programs are proven to save lives and money."

(American Legacy Foundation 2002)

- Earmark any additional tobacco tax for those affected by tobacco use. It is only fair and decent to give smokers who may be taxed additionally the services to help them quit.
- Fund the Tobacco Control Program at 25% of the tobacco industry's expenditures on advertising and promotion in California.
- Do not divert any funds from the Proposition 99 Health Education and Research Accounts to other state programs or services. The courts have ruled that these funds must be used as the voters intended.

TABLE 2
Budget Necessary to Return the Tobacco Control Program to Same Ratio of Spending to the Tobacco Industry That Existed During the First Four Years of the Program

Program Component	Original Share of Tobacco Control Program (percent of total)	Necessary Expenditures (2002 dollars in millions)[8]	FY 2002-03 Budget (in millions)	Underfunding (2002 dollars in millions)
CDHS/TCS	51%	$153.7	$60.4	$93.3
CDE/HKPO	25%	$75.4	$28.0	$47.4
UC/TRDRP	24%	$72.3	$19.4	$52.9
TOTAL		**$301.4**	**$107.8**	**$193.6**

TABLE 3
Budget Proposal for the Tobacco Control Program, Fiscal Years 2002 - 2005

Program Component	Actual FY 2002-03 Budget (in millions)	Recommended FY 2002-03 Budget (in millions)	Recommended FY 2003-04 Budget (in millions)	Recommended FY 2004-05 Budget (in millions)
CDHS/TCS	$60.4	$153.7	$158.3	$163.1
CDE/HKPO	$28.0	$75.4	$77.6	$79.9
UC/TRDRP	$19.4	$72.3	$74.5	$76.7
TOTAL	**$107.8**	**$301.4**	**$310.5**	**$319.7**

Note: Budgets for future years were estimated using a 3% inflation rate.

- Offset declines in Proposition 99 funding for the California Tobacco Control Program (including the California Department of Health Services, the California Department of Education, and the University of California) with other funds (e.g., the General Fund, additional tobacco tax), and adjust the funding level to keep pace with inflation.

OBJECTIVE 2.
Increase the price of tobacco products.

TEROC recommends that the price of tobacco products be increased through an excise tax increase or other means, commensurate with its cost to society. This cost currently translates to $11.34 per pack of cigarettes (Max et al. 2002). TEROC further recommends that, when the price of tobacco products is increased, at least 20 cents per pack of any tobacco tax increase be earmarked for tobacco control and that this rate should be indexed to inflation. Research has shown that the best way to reduce youth smoking and access is to increase the price of tobacco, since young people are especially price-sensitive (Chaloupka and Pacula 2001). In addition, an earmarked tax increase would begin to pay for the costs of tobacco use to society in health care, lost productivity, and deaths.

[8] *These figures are actual expenditures by CDHS/TCS, CDE/HKPO, and UC/TRDRP as opposed to the proportions designated in Proposition 99. The reason for the difference is due to the fact that not all of the allocated revenues were spent in the first few years of the Program; therefore the proportions are different than what was intended.*

A tax increase, and the resulting higher cost of cigarettes, would also accrue many health benefits to Californians who presently smoke. For example, if the tax on cigarettes were increased by $2.13 (as proposed by Speaker Herb Wesson in August 2002), there would be nearly 590,000 new quitters in the state and over 320 million unsmoked packs of cigarettes per year. In the first year following a tax increase, 500 heart attacks and 150 heart attack deaths, and 250 strokes and 100 stroke deaths would be prevented. Four-hundred low birth-weight births, 550 new childhood asthma cases, and 20 sudden infant death syndrome cases would be prevented. Millions of dollars in prevented medical expenditures would be saved (e.g., $24 million from prevented cardiovascular disease, $2.5 million from prevented neonatal care, $600,000 from prevented childhood respiratory illnesses).

(Ong and Glantz 2002)

Recommended Strategies for Reaching Objective 2

- Immediately increase the tax on tobacco products by at least 50 cents, with 20 cents earmarked for Proposition 99 Health Education and Research Accounts.
- Impose a $1.00 per cigarette pack (and equivalent rates on other tobacco products) mitigation fee[9] to be used for increased cessation counseling and treatment for tobacco dependence.
- Prohibit special promotions that reduce the price of tobacco (for example, 2 for 1 specials).
- Remove barriers in state law to allow cities and counties to tax tobacco products.
- Support research on the effect of increasing the price of tobacco products on use patterns on California's diverse population.
- Require that any tobacco excise tax increase include a provision to backfill the tobacco control, education, and research programs for any loss of revenues caused by the increase.

OBJECTIVE 3.
Work toward eliminating disparities and achieving parity in all aspects of tobacco control.

Tobacco-related disparities still exist for communities of color (African Americans, Asian Americans and Pacific Islanders (AAPIs), Hispanic/Latinos and Native Americans) and other priority populations (low socioeconomic status; lesbian, gay, bisexual, transgender (LGBT); women; rural communities; school-aged youth, and young adults 18-24).

For example, African Americans have the highest lung cancer incidence and mortality rates of the four major ethnic population groups. American Indians and specific AAPI subgroups have some of the highest prevalence of smoking, and Hispanic/Latinos are the least protected group in terms of secondhand smoke in the workplace. Some of these disparities are related to tobacco industry targeting. There is ample evidence that communities of color, LGBTs, and youth, for example, continue to be targeted by tobacco companies not only in the United States but worldwide (e.g., Chen et al. 2002).

There are also historic inequities in resource allocation, capacity building and program infrastructures, and representation and involvement in policy and decision-making processes. California has been at the forefront in addressing these disparities. Proposition 99-funded ethnic tobacco education networks are a model for the nation, and competitive grantees that focus on the role of culture in tobacco prevention and countering industry marketing and promotion have helped to bridge the gap in parity in tobacco control. Nevertheless, although California has addressed tobacco-related disparities for priority populations more than other states, more research is needed to support and guide interventions, and programs must be strengthened and enhanced.

As new populations of immigrants come into California, cultural and norm-changing efforts must be expanded even further into the various subgroups within these communities of color and other priority populations to address disparities in tobacco prevention and cessation research, programs and services.

[9] *In the California Supreme Court's decision in Sinclair Paint Co. v. State Board of Equalization (1997), the Court ruled that the State can impose a charge to mitigate the social or economic burdens that a business causes. To mitigate the $15.8 billion that cigarette addiction costs the State, TEROC calls upon the Legislature to create a special fund for direct cessation treatment through the equivalent of a $1.00 per pack fee on cigarettes. The fee imposed should be proportional to the cigarette manufacturer's or distributor's contribution to the economic effect of their products. The fund would go to pay for services to smokers to help them quit smoking.*

Disparities in exposure to secondhand smoke at work: *20.4% of Hispanic nonsmokers reported being exposed to smoke at their indoor workplace in the previous two weeks; 19.7% of Asian/Pacific Islanders were exposed; 15.3% of African Americans, and 12.4% of non-Hispanic Whites (1999 California Tobacco Survey).*

Disparities in smoking prevalence: *There are twice as many people without medical insurance (30.4%) or with Medi-Cal (30.1%) who smoke as those with private insurance (15.3%) who smoke.*

(2001 California Adult Tobacco Survey)

Recommended Strategies for Reaching Objective 3

- Provide adequate and continued funding for communities of color and priority populations to address tobacco issues comprehensively (including strengthening and expanding capacity building and leadership development programs) at the state and local level.
- Continue to fund the four statewide ethnic networks at adequate levels, and provide funding for a LGBT statewide project or network.
- Increase research funding for priority populations, including studies on effective outreach and cessation strategies that are culturally tailored and community specific, and that focus on subgroup variability and the diversity within these populations.
- Continue to support academic/community and academic/school-based partnerships to conduct participatory research that is scientifically sound and grounded in California's diverse population.
- Make obtaining research data to support and strengthen programmatic interventions for diverse populations a high priority.
- Develop a mechanism to ensure and monitor the representation and inclusion of communities of color and other priority populations in the strategic planning, policy setting and decision-making bodies and processes in statewide and local tobacco control organizations and agencies.
- Develop and maintain cultural competency standards for Proposition 99-funded organizations to work with diverse communities, and train staff, boards, and decision makers in these standards.
- Continue to fund the media campaign to develop community-specific and culturally-tailored advertisements in appropriate languages. This should also include media literacy activities to expose and counter tobacco industry tactics and influence among priority populations.

- Provide funding for educating the public about transnational tobacco issues, particularly as they impact new arrivals from countries with prolific tobacco advertising and strong pro-smoking norms. Approximately 25% of Californians are foreign-born.
- Increase funding to educate priority populations about secondhand smoke in homes and other living environments, and encourage the voluntary adoption of smoke-free homes and other living environments.
- Support initiatives within the schools that focus on cultural diversity and that work with adjacent communities in tobacco prevention among youth.
- Fund and provide effective mechanisms to regularly convene representatives of communities of color for discussion of tobacco issues to address disparities.

OBJECTIVE 4. Decrease exposure to secondhand smoke.

Secondhand tobacco smoke contains carcinogens for which there is no safe level of exposure, and is a leading cause of preventable death in California. Nobody should be involuntarily exposed to secondhand smoke where they work, live, or play. TEROC recommends that California maintain and expand its smoke-free workplace protections; increase enforcement of public policies promoting smoke-free environments; and implement a campaign for smoke-free shared spaces, including all indoor and outdoor public spaces and common areas of multi-unit residential housing. Further, TEROC recommends that the California Tobacco Control Program encourage the development and implementation of local policies, both voluntary and mandatory, to reduce and eliminate exposure to drifting secondhand smoke everywhere.

There is popular support for increased smoke-free policies. A January 2001 Field poll of 1812 adults, undertaken for the Department of Health Services, found that 90% agreed that nursing homes and other long-term health care facilities should be smoke-free; and 86% agreed that hotel and motel lobbies and common areas such as swimming pools and fitness rooms should be smoke-free.

> *Smoke-free workplaces not only protect non-smokers from passive smoking but also encourage smokers to quit or reduce their consumption, reducing total cigarette consumption per employee by 29%.*
>
> *(Fichtenberg and Glantz 2002)*

Recommended Strategies for Reaching Objective 4

- Continue to educate the public, including youth, on the health effects of secondhand smoke and on the tobacco industry's efforts to deny these effects.
- Recognizing that Labor Code 6404.5 (The California Smoke-Free Workplace Act) is not preemptive, pass restrictions at the local level eliminating exceptions and expanding protections found in LC 6404.5.
- Pass restrictions on outdoor smoking (building entry ways, college campuses, health facilities, prisons, fair grounds, amusement parks, concerts, sporting events).
- Promote voluntary home/car smoke-free policies.
- Ensure consistent local compliance and enforcement of state and local smoke free workplace laws (including bars), tobacco-free policies in schools, and secondhand smoke restrictions in outdoor areas. Enhance protections through voluntary smoke-free policies and ordinances to protect residences from drifting smoke in apartments, condos, and other shared residences.
- Require the Department of Alcoholic Beverage Control to assist in enforcing the smoke-free bar law by considering compliance with this law when renewing liquor licenses.
- Educate policy makers on ventilation issues: that ventilation technology does

not exist to control the health effects of secondhand smoke.

- Conduct research on indoor and outdoor secondhand smoke exposure, including attitudes, beliefs, enforcement, and health effects.

OBJECTIVE 5. Increase availability of cessation assistance.

Tobacco use cessation is a desired outcome of all initiatives and activities of the Tobacco Control Program, and all tobacco users (including smokeless tobacco users) should have access to culturally and linguistically appropriate cessation assistance. For this to occur, changes are necessary in the health care environment. TEROC recommends that there be a new funding source for dedicated cessation services, such as the proposed mitigation fee (see Objective 2), and that health care providers — including Medi-Cal — offer smoking cessation treatment as a covered core benefit.

Recommended Strategies for Reaching Objective 5

- Integrate cessation services in the State, including school- and community-based interactive cessation services, with the California Smokers' Helpline.
- Increase the capacity of cessation services to provide assistance to tobacco users in diverse communities and in a variety of languages.
- Encourage health care providers to routinely assess the smoking status of their patients and implement Public Health Service (PHS) guidelines for smoking cessation (i.e., the 5 A's: Ask, Assess, Advise, Assist, Arrange).
- Advocate for cessation coverage as a core benefit from the health insurance industry (Medi-Cal, HMO's, private insurers), including culturally proficient medical counseling and medically mediated treatment, such as nicotine replacement therapy and other pharmaceutical aids.
- Support research on cessation strategies for priority populations, including teens and low-income individuals.
- Support research on the barriers to providing cessation counseling and services by health care professionals and in the workplace.
- Support programs to incite health care professionals' engagement in cessation counseling and referrals.

OBJECTIVE 6. Initiate efforts to regulate the tobacco industry and its influence.

The tobacco industry continues aggressively to market products known to be addictive and cause the premature death of tens of thousands of Californians and hundreds of thousands of Americans each year. Given the staggering impact it is having on the public's health, TEROC recommends that state as well as local governments in California strictly regulate the tobacco industry at every level of its operation, from product manufacture to retail sale, including the elimination of the sale of tobacco products in chain drug stores and pharmacies and other appropriate retail venues. Industry activities must be exposed and monitored, and regulatory action must be taken to eliminate its messages and tactics aimed at recruiting new smokers and perpetuating the addiction of current tobacco users. (The industry's tactics and continued influence on youth and other priority populations are documented in the section, "Victory as Myth," pages 10–14.)

TEROC commends Attorney General Bill Lockyer for actively and aggressively enforcing provisions of the Master Settlement Agreement, and calls upon both the California Legislature and the U.S. Congress to enact legislation that will further regulate the tobacco industry. TEROC also calls upon the tobacco industry to change its behavior in accordance with expected corporate accountability to the public.

Recommended Strategies for Reaching Objective 6

- Ask California members of Congress to support strong FDA regulation of the tobacco industry.
- Ask members of the California Legislature and other public officials to refuse donations from the tobacco industry, its representatives, and its subsidiaries.
- Encourage voluntary policies by community, public, and private organizations to refuse tobacco industry sponsorship and donations (e.g., for community events, school events, college-related events, special programs, "bar nights"), and encourage alternative sources of funding for those events.
- Ask the Attorney General to hold the tobacco industry accountable by continuing to actively enforce provisions of the Master Settlement Agreement.

...Tobacco is an issue teens encounter every day. Many young people recognize the dangers of tobacco use. Many have lost a family member to the ravages of tobacco-related disease. Many dislike the smell and look of cigarettes or spit tobacco. Yet they may also feel helpless in the face of relentless advertising, peer pressure, or their own lack of knowledge about how to influence the community around them. Tobacco prevention and control is an issue that arouses their passions, and provides a terrific window of opportunity to get youth involved in a community mission with social justice at its root.

(California Healthy Cities and Communities 2000)

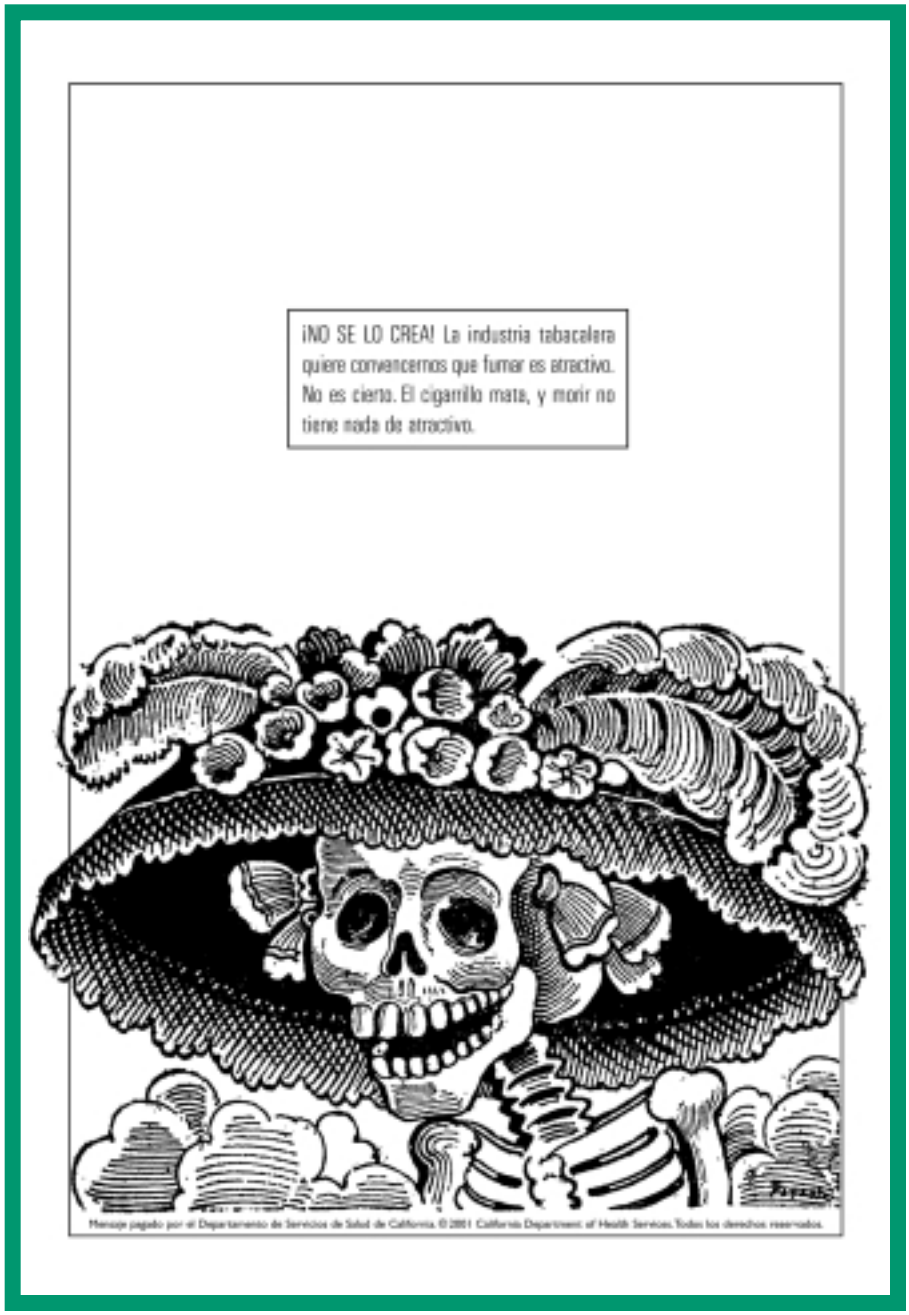
- Promote legislation to require ingredient disclosure on tobacco products sold in California.
- Promote legislation to license retailers of tobacco products, and enforce the consequences of violation. Licensing legislation should adhere to the following standards:
  - Local control is not preempted, and licensing provisions do not limit or render inapplicable any other current tobacco control regulations or prohibitions;
  - A fee is charged to retailers to cover program administration and enforcement and is annually renewed;
  - Effective enforcement is built in;
  - Penalties for violation are meaningful, graduated, and result in suspension and revocation of license;
  - Violations of any tobacco control laws, not only PC 308 (illegal sales to minors), are included in enforcement; and
  - The licensing process is administered by the California Department of Health Services.
- Oppose any preemptive statewide legislation (e.g., legislation that prohibits local government entities from adopting stronger regulatory measures).
- Continue to closely monitor activities of the tobacco industry and its allies in order to anticipate, expose, and counter their tactics.
- Support research on point of sale tobacco advertising and promotions such as buy-downs and use of a product as a form of advertisement.
- Support strategies to control direct marketing and point of purchase tobacco promotions, including the promotion and sale of tobacco products by pharmacies and chain stores.
- Ask the entertainment industry to take the following steps to address smoking in films:
  - Post a certificate in the credits declaring that no one in the production received anything of value for using or displaying tobacco;
  - Require a strong anti-smoking ad to run before any film with any tobacco presence;
  - Show no tobacco brand identification in any movie scene; and
  - Rate "R" any film that shows or implies tobacco.[10]
- Support the elimination of tobacco promotions and sales on college campuses.
- Educate the public about transnational tobacco industry practices, including child labor and environmental degradation, hold the tobacco industry accountable, and support a strong Framework Convention for tobacco control.
- Monitor and oppose tobacco industry direct and indirect pressure to neutralize Tobacco Control Program activities.
- Maintain a focus on regulating the tobacco industry, and resist efforts to deflect the focus onto those who are targeted by the industry (such as raising the legal age for purchase of tobacco products to 21).

[10] *Because an R rating reduces the potential theatrical and television audience (and profits), this recommendation is intended to provide an economic disincentive to producers to include smoking and other tobacco promotions in their films. The Smoke Free Movies Project (www.smokefreemovies.ucsf.edu) notes that youth who see lots of smoking in movies are two and a half times more likely to smoke than youth who see movies with little smoking, and children whose parents restrict their viewing of R movies are less likely to smoke.*

Progress Toward TEROC's 2000-2002 Master Plan

This chapter provides an overview of the achievements of the California Tobacco Control Program between 2000 and 2002 in terms of the progress made toward TEROC's recommendations; changes in cigarette consumption and smoking prevalence; population health benefits derived from cessation; and levels of exposure secondhand smoke. Anecdotes of many programs funded by the Program's three administering agencies — the Tobacco Control Section, California Department of Health Services, the Healthy Kids Program Office, California Department of Education, and the Tobacco-Related Disease Research Program, University of California — also illustrate local successes around the state.

The most important lesson of California's experience with tobacco control is that it is possible to rapidly reduce tobacco consumption despite the aggressive, lavishly funded marketing and promotion of tobacco products. Since the passage of Proposition 99, cigarette consumption and smoking prevalence have declined, secondhand smoke exposure has decreased, and health benefits have accrued.



Even the tobacco industry is on record about the success of California's program: "Beyond shaping public opinion, the State's Tobacco Control Program has had other effects. Perhaps most significantly, the State has urged Californians to believe that cigarette companies are responsible — and thus to blame — for the health consequences of smoking. The initiative has succeeded. Approximately 70% of Californians believe that the tobacco companies have lied to consumers in the past, and bear responsibility for proving that they are telling the truth."

(Attorneys for R.J. Reynolds, Memorandum 2002)

TEROC's 2000-2002 Recommendations

In its last Master Plan, *Strategies for the 21st Century,* TEROC made eleven recommendations for the years 2000-2002. This section assesses the progress made regarding these recommendations.

Progress Toward Recommendation 1:
Increase funding for the California Tobacco Control Program so that it can build on past successes and take advantage of new opportunities to reduce tobacco consumption rapidly.

- California has moved backwards in terms of this recommendation. The 2002-2003 state budget cut the California Department of Health Services/Tobacco Control Section (CDHS/TCS) funding by $46 million compared to the previous fiscal year. This included a reduction of $24,152,000 in the media campaign, $18,915,000 in local programs, and $2,227,000 in evaluation. Regional programs were eliminated. CDHS/TCS was also appropriated no Master Settlement Agreement funds in 2002-2003.
- The University of California/Tobacco-Related Disease Research Program (UC/TRDRP) experienced a 14% reduction in funding, due to declines in tobacco tax revenues and allocations from the Research Account to the CDHS California Cancer Registry. While the Cancer Registry serves, in part, as a research resource, its primary purpose is surveillance to support CDHS programs in general. It should be funded from the CDHS general budget, not the tobacco program, as it was in the past.
- For the first time, in FY 2001- 2002, the CDHS/TCS was able to use $20 million in Master Settlement Agreement funds to support 56 new projects that target 18-24 year olds, carry out enforcement of tobacco control laws, and develop advanced youth coalitions. These MSA funds were eliminated in the FY 2002-2003 budget.
- CDHS/TCS witnessed an augment in the media campaign from $19 million in Fiscal Year 1999-2000 to $45 million in FY 2000-01 and 2001-02. These additional funds resulted in expanding both general market and ethnic media (print, radio, TV, and outdoor ads). In FY 2002-03, these funds were reduced to $21 million.

Progress Toward Recommendation 2:
Expand the Tobacco Control Program and strengthen its fundamental structure, focus, and key messages.

- CDHS/TCS continues to focus its efforts within four priority areas: 1) countering pro-tobacco influences in the community; 2) reducing exposure to secondhand smoke and increasing the number of smoke-free public spaces; 3) reducing the availability of tobacco products; and 4) increasing the availability of cessation services.
- CDHS/TCS created the Communities of Excellence (CX) process for Local Lead Agencies (LLAs). LLAs conducted assessments of their communities in relation to a number of tobacco-related indicators and assets in preparation for developing their new 2001-04 comprehensive work plans.
- CDHS/TCS created the Online Tobacco Information System (OTIS), a searchable database for accessing process information on CDHS/TCS-funded projects.
- CDHS/TCS funded statewide studies of tobacco-related attitudes and behavior in five priority populations in

California. They are Chinese, Korean, East Asian, LGBT, and active military.

- The California Department of Education/ Healthy Kids Program Office (CDE/HKPO) continues to: 1) require schools to be tobacco free; 2) provide cessation programs to students and staff, and inform staff, students, parents and the community about these programs; 3) require schools to adhere to the federal Principles of Effectiveness; and 4) conduct on-site monitoring reviews of schools.
- UC/TRDRP has expanded its research priorities to incorporate targeted as well as emerging tobacco control issues; funded more research projects directly related to tobacco use prevention and control; enhanced the State's research capacity and infrastructure; and disseminated the results of TRDRP-funded research to the tobacco control community.

Por La Vida Taking Action for Tobacco-Free Communities. *The Por La Vida project in San Diego uses existing social networks in the Latino community to change community norms around tobacco. Latinas from the community serve as consajeras to educate and empower residents to build smoke free environments for themselves. There are activities on responsible sales practices, parent-child communication around tobacco, and tobacco-free celebrations. This project received funding from the Tobacco-Related Disease Research Program (TRDRP).*

SimSmoke Computer Model. *TRDRP also funded the California SimSmoke computer model that can predict smoking and smoking related deaths based on population subgroups and the public policies that are in effect — such as taxes, mass media, clean air laws, treatment to stop smoking, and youth access to tobacco. Californians can use the computer model to see how different policies affect tobacco use, which in turn affects tobacco-related deaths in specific ages, genders, and racial/ethnic groups. Thus the value of each policy to various population groups can be monitored and future policies shaped.*

Progress Toward Recommendation 2a: Continue to anticipate, vigorously expose, and counter tobacco industry tactics.

- CDHS/TCS supported Project SMART $ (Sponsorship Mission: Avoid Reliance on Tobacco) efforts to adopt policies prohibiting tobacco industry sponsorship of local events/venues/ organizations.
- CDHS/TCS created the STORE Campaign, a comprehensive tobacco control approach to the retail tobacco environment.
- CDHS/TCS funded efforts to monitor tobacco industry practices.
- The media campaign created aggressive ads targeting the tobacco industry (many of which are used in this Master Plan).
- The emergence of the Philip Morris External Research Program in 2000 returned the issue of tobacco industry research funding to the spotlight. An issue of the UC/TRDRP newsletter was devoted to this topic, and UC/TRDRP will be educating UC/TRDRP investigators and researchers nationwide about the ethics and consequences of accepting tobacco industry research funds, and the industry's history of misusing research.
- UC/TRDRP provided initial funding for establishing the tobacco industry documents library at the University of California, San Francisco. This investment led to a $15 million grant from the American Legacy Foundation to enable investigators to explore the documents in depth.

PROJECT SPONSORSHIP MISSION: AVOID RELIANCE ON TOBACCO (SMART) MONEY

Project SMART Money is a grassroots movement committed to eliminating tobacco company sponsorship of California's diverse events and organizations. The primary goal of Project SMART Money is to prevent another generation from being addicted to tobacco. To eliminate tobacco company sponsorship, Project SMART Money members work to generate public awareness of the consequences of allowing tobacco companies carte blanche access to our communities and to break the addiction to tobacco funding among sporting, cultural and civic events and organizations. Sponsorship of community events is just one more weapon in the arsenal of the tobacco industry to target new customers for its deadly products.

In 2000 and 2001, the tobacco industry sponsored among others 53 pro rodeo events, 9 college rodeo events, 14 NASCAR races, 26 dance events, 7 fishing events, and 9 rugby events. California tobacco sponsors in 2002 included Winston, Skoal, Marlboro, Kool, Philip Morris, Lorillard, and USST. Most of these sponsored events were televised (TIME Project, University of Southern California).

Project SMART Money is also working with the State Attorney General's Office to monitor whether tobacco companies are complying with the sponsorship terms of the Master Settlement Agreement between the state attorneys general and the tobacco industry. Approximately 40 public health and tobacco education organizations, representing cities, counties and community-based organizations across the state have teamed to initiate the Project.

Progress Toward Recommendation 2b: Continue to press for smoke-free workplaces, public places, events, schools, and homes.

- CDHS/TCS provided information on how to implement HSC 104498, the new California law that prohibits smoking on playgrounds and tot lots.
- CDHS/TCS awarded law enforcement grants to increase compliance with the state and local secondhand smoke and other tobacco-related laws.

An innovative Latino art post card campaign was developed by the California Hispanic/ Latino Tobacco Education Network to provide key messages to the Latino community on tobacco control. These low-cost post cards contain bilingual educational messages regarding the dangers of secondhand smoke, the attempts of the tobacco industry to manipulate the Latino community with product placement and advertising, and the importance of the Latina's role as gatekeeper for the health of her family and community.

- CDHS/TCS held the first national secondhand smoke conference in San Diego.
- CDHS/TCS conducted Field polls on bar patrons' and the general public's opinions regarding exposure to secondhand smoke in non-bar environments.
- CDHS/TCS updated the existing Smoke-Free Workplace Law brochure and completed two case studies on implementing the Smoke-Free Bar Law.
- The statewide media campaign created 22 ads focusing on secondhand smoke, including ads in Spanish, Cantonese, Mandarin, Vietnamese, Korean, Japanese, Hmong, Cambodian, and Laotian.
- CDE/HKPO requires all local school boards to adopt and enforce a tobacco free policy (on school property, in cars, and at any school-sponsored event) and to communicate this policy to all staff, students, parents and the community.
- Compliance with school smoking policies increased 64% between 1996 and 1999, with two-thirds of the students interviewed perceiving that their school's smoking ban was generally obeyed. In 1999, the vast majority of students (89%) supported a complete ban on smoking on school grounds (Gilpin et al. 2002).

COUGH CAMPAIGN

COUGH (Campuses Organized and United for Good Health) is a statewide policy campaign to educate campus communities — students, faculty, staff — about issues surrounding tobacco and encourage support of stronger campus smoke-free policies. COUGH was initiated in response to a memo from the California State University (CSU) General Counsel that no CSU campus could adopt a smoke-free policy that exceeds the state law of a 5-foot doorway perimeter. Any policy must be through action by the CSU Board of Trustees. The first victory for COUGH in September 2002 was an amendment by the Board of Trustees that gave power back to individual campus presidents to create their own policies. COUGH encouraged presidents to create a 20-foot minimum smoke-free doorway policy, and is also encouraging campuses to become completely smoke-free.

Progress Toward Recommendation 2c:

Increase population-based smoking cessation activities through the media campaign, the California Smokers' Helpline, and coordination at the local community level.

- Through the media campaign, Local Lead Agencies, and competitive grantees, CDHS/TCS continues to support cessation activities and the California Smokers' Helpline.
- CDE/HKPO provides intensive readiness for cessation and cessation strategies for pregnant and parenting teens. School districts are required to reach this population early and frequently.
- More than three out of every four California smokers say they would like to stop smoking. The rate of successful quitting, defined as 90 or more days of abstinence, has not changed since 1990. However, 61.5% of smokers made a quit attempt in 1999 that lasted one day or longer, which is a 25.7% increase over the 1990 rate of 48.9%.

Progress Toward Recommendation 2d:

Implement strategies (including youth anti-tobacco advocacy to promote smoke-free environments) to reduce youth demand for tobacco, rather than focusing primarily on youth access.

- CDHS/TCS continues to support social norm change strategies that create a social milieu and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible. This approach does not focus on youth access, but rather is grounded in the belief that to impact youth tobacco use one must change the environment in which youth grow up.
- CDE/HKPO supports the involvement of youth in Friday Night Live, an after-school youth development advocacy activity.
- CDHS/TCS also funds several projects that further address youth issues and include youth in the tobacco control movement. These include "Youth 2K and Beyond," a conference for public health and education practitioners on

YOUTH ADVOCACY COALITIONS

A number of youth coalitions are active in advocating for tobacco control around the state, especially through the passage of local policies. Some of the accomplishments of local youth coalitions include:

- *Development of an ad publicizing sales of tobacco products to minors and the 1-800-ASK 4 ID number (Stanislaus County).*
- *Implementation of a smoke-free policy at a movie theater (Stanislaus County).*
- *Publicizing two tobacco litter collections at a local beach (San Diego County).*
- *Presentation of surveys documenting exposure of youth to secondhand smoke in youth-frequented areas of Sacramento to the City of Sacramento Downtown Partnership. The documentation helped convince the Partnership to prohibit all tobacco industry sponsorship of their three high-profile public events for 2002 (Sacramento County).*
- *With the support of Legislator Carol Washington, youth are helping to get a licensing ordinance passed in the City of Lynwood.*
- *Production of tobacco awareness materials to promote a selective purchase policy in the Nevada Joint Union High School District: "Did You Know?" facts were printed on cafeteria napkins, and a similar apron was created for cafeteria staff.*

On the state level, the California Youth Advocacy Network helped to create a Statewide Youth Coalition, which conducted two campaigns — one to educate the public about three new state tobacco laws, and another to celebrate the "tot lot law" six months after its enactment.

an evidence-based approach to developing strategies to reduce youth demand for tobacco; youth advocacy coalitions; local programs targeting college campuses, young adults in blue-collar jobs, and entertainment venues frequented by 18-24 year olds.

Monterey County, campaign to counter tobacco industry "bar nights" for 18-24 year olds.

Progress Toward Recommendation 3:

Continue to strengthen and increase accountability of school-based tobacco use prevention education programs, consistent with principles of effectiveness.

- CDE/HKPO requires Tobacco Use Prevention Education (TUPE) programs to adhere to the federal Principles of Effectiveness, which require a needs assessment, performance indicators, research-based prevention programs, and evaluation of progress in reducing the use of tobacco products.
- TUPE programs utilize the California Healthy Kids Survey (CHKS) to assess their progress, and CDE/HKPO offers approximately 30 workshops annually to assist schools in analyzing and interpreting the data from their surveys. Data can be compared to state level results from the California Student Assessment, and to national data in the Youth Risk Behavior Survey.

TOBACCO USE PREVENTION EDUCATION IN SCHOOLS

Evaluations of eleven school-based projects, funded by the California Department of Education's TUPE Program, found that the programs changed the tobacco related attitudes and/or behavior of students. Some of the most effective programs were:

The Missing Link: Personal and Social Skills Lessons for Drug, Alcohol, Tobacco and Violence Prevention (Los Angeles County Office of Education)*. Skills-based lessons for 7th and 8th graders.*

Smokeless School Days (Los Gatos-Saratoga Joint Union High School District). *Students caught in possession of tobacco products attend a 4.5 hour session to move them to cessation awareness.*

Triple T: Teens Tackle Tobacco (Napa County Office of Education). *Art-focused tobacco prevention strategies for grades 6-12 that use teens as health educators.*

Medicine Wheel (Resources for Indian Student Education). *Youth leaders help other high school students to distinguish between commercial abuse of tobacco and appropriate traditional uses of native plants by American Indians.*

Tobacco Free Generations — Well Into the Future (Sacramento County Office of Education). *Students in pregnant and parenting classes receive tobacco prevention lessons that use multicultural aspects and artwork.*

Project ALIVE! (Stanislaus County Office of Education). *Peer education activities in visual and performing arts create awareness and support strategies to promote a tobacco-free lifestyle.*

- CDE/HKPO provides school districts with the latest research literature on tobacco prevention and youth development in five publications in the *Getting Results* series, which are updated annually.
- Currently, as mandated by law, grades 4 through 8 receive TUPE funding as an entitlement (based on average daily attendance) while grades 9-12 receive funds through a competitive grant process. Middle schools also receive funding for "promising" grants through a competitive process.
- Because of a recent state hiring freeze, there are three health education consultant position vacancies in CDE/HKPO. No progress was made in increasing the staffing at the state level to administer and provide technical assistance to TUPE competitive grantees.

Progress Toward Recommendation 4: Increase the collaboration and communication among and between school-based and public health-based tobacco control programs.

- CDHS/TCS and CDE/HKPO together are collaborating with the California Attorney General's Office (Crime and Violence Prevention Center and Tobacco Litigation Section), the California Youth Advocacy Network, and the California Legacy Program.
- CDHS/TCS and CDE/HKPO launched the "Advertising: How Does It Rate?" survey with 350,000 students in grades 5-12 and alternative schools, in which the students rated their preferences for anti-tobacco ads from the Tobacco Control Program.

CALIFORNIA'S LEGACY PROGRAM

Established in 2001, California's Legacy Program is designed to increase youth leadership and involvement in tobacco control advocacy at the state and local levels. The program is a partnership between the California Department of Health Services, Tobacco Control Section; the California Department of Justice, Office of the Attorney General's Tobacco Litigation and Enforcement Section and its Crime and Violence Prevention Center; the California Department of Education, Healthy Kids Program Office; and the California Youth Advocacy Network. It was funded by a youth empowerment grant from the American Legacy Foundation.

The program established six new local youth tobacco control advocacy coalitions, supported activities of the existing statewide youth coalition, enhanced the efforts of other existing local youth coalitions, linked graduating high school seniors to college-based tobacco control programs, and trained youth and adult coordinators on a variety of topics that support tobacco control advocacy such as public speaking, leadership skills, media awareness, group facilitation skills, and community organizing. In addition, the program sponsored a three-day conference on youth/adult partnerships entitled Uniting the Generations, *and the Office of the Attorney General, Crime and Violence Prevention Center is creating a series of three videos on youth tobacco control advocacy.*

- CDHS/TCS continues to collaborate with school-based tobacco control programs by:
  - Funding the San Diego City School District to complete an analysis of the intervention schools receiving the *Life Skills* curriculum and those that did not, and funding the development of a marketing tool for use by LLAs to promote the use of evidence-based curricula by schools;
  - Funding nine Advanced Youth Coalitions of middle- and high-school aged youth to engage in anti-tobacco advocacy and leadership activities;
  - Conducting school-based data collection for the California Student Tobacco Survey and Schools Evaluation.
- CDHS/TCS encourages the continued involvement of schools on LLA coalitions.

Progress Toward Recommendation 5:

The University of California's Tobacco-Related Disease Research Program should continue to encourage and fund research that makes specific contributions to tobacco control.

- UC/TRDRP-funded research in social and behavioral science, public policy, and epidemiology has focused primarily on bolstering California's tobacco control efforts. Between 2000 and 2002, UC/TRDRP funded over 60 research projects on: smoking cessation, youth tobacco use prevention, community tobacco control programs, public policy alternatives, the identification of new and emerging smoking groups. Most of the research in these categories focuses on the smoking practices and habits of California's burgeoning multiracial and multiethnic population. Furthermore, UC/TRDRP has funded research on tobacco use by other priority populations that is not well supported by other funding agencies, including women, LGBTs (Lesbian, Gay, Bisexual and Transgender), low socioeconomic status, youth, deaf, and smokers in rural areas.
- UC/TRDRP encouraged surveillance research as a priority to encourage the monitoring and evaluation of trends in tobacco use and tobacco-related disease risk factors, and expanded its epidemiological research priority.
- UC/TRDRP funded research on tobacco use prevention; the relationship between tobacco use and acculturation among Latinos, Asian/Pacific Islanders, and other immigrants; resistance to tobacco use among African American youth; and increased smoking prevalence by young women.
- The policy research priority was expanded to explicitly encourage economic research.
- UC/TRDRP has increased its efforts to enhance the State's research capacity and infrastructure through mechanisms such as the Community-Academic Research Awards and the School-Academic Research Awards. TRDRP is working with the National Cancer Institute in its efforts to launch this type of collaborative research at the federal level.

SCHOOL-BASED PROGRAM FOR DEAF AND HARD OF HEARING YOUTH.

A new UC/TRDRP School-Academic Research Award (SARA) is creating a comprehensive school-based anti-tobacco program for deaf and hard-of-hearing youth. Through a partnership of the California School for the Deaf and the University of California, Los Angeles, a tobacco prevention and cessation program that addresses aspects of deaf youth culture and experience in various educational settings (mainstream and residential/day school) is being developed. This project was funded jointly by UC/TRDRP and CDE/HKPO.

DETERMINANTS OF SMOKING AMONG GAY AND LESBIAN YOUTH.

Different subgroups of youth show greater risk for regular tobacco use, and tobacco use is more prevalent among gay and bisexual men and lesbians and bisexual women than among the general population. Another important research finding is that adolescents who are "deviant prone" are more vulnerable to use of tobacco and other drugs. Interviews with gay, lesbian and bisexual youth is identifying the factors associated with experimentation and regular use of tobacco. This information will then be used to develop effective anti-tobacco and cessation programs for gay and lesbian youth. This project received funding from UC/TRDRP.

- UC/TRDRP funded the University of California, San Francisco Library to create the Tobacco Control Archives, which garnered a $15 million award from the American Legacy Foundation to put the tobacco industry documents online as a permanent resource.
- UC/TRDRP disseminates research findings through its Annual Investigator meetings; a quarterly newsletter; and conferences and symposia.

Progress Toward Recommendation 6:
The Administration should implement policies and procedures to assure rapid development and approval of the media campaign to permit the campaign to respond quickly to the changing environment.

The approval process for the media campaign remains a serious problem. Despite earlier assurances that there would be a 72-hour approval time for new media, the approval process has continued to drag on, often for months, and is not well described to TEROC. In summer 2000, the Davis Administration did release 31 advertisements approved in 2000, 39 approved in 2001 (compared with a total of 26 ads in 1998 and 1999). However, only 8 were approved in 2002.

The slow approval process has led to advertisements that do not have the same level of timeliness or edginess that once was the reputation of the California campaign. California's advertisements are no longer viewed as cutting edge in comparison with ads produced in other states and by the American Legacy Foundation.

On November 4, 2002, CDHS Director Diana Bontá wrote a letter to TEROC that detailed a policy of review for media materials. This policy states that there will be a 72-hour turn around for all advertisements at each level of the approval process, including the CDHS Director's office, the Health and Human Services Agency, and the Governor's office. TEROC applauds this policy.

To ensure that it is properly implemented, TEROC recommends that the Administration provides formal written notice to the Chair of TEROC throughout the approval process, including notification when the advertisement is submitted by CDHS/TCS, approval is granted by the Director of CDHS, approval is granted by the Agency, and approval is granted by the Governor.

Progress Toward Recommendation 7:
Medically mediated nicotine-dependence treatment should be a benefit of the health care delivery system.

- CDHS/TCS has encouraged the provision of cessation services through private insurers through its collaboration with CalPERS and through funding opportunities to community based organizations for system-level cessation interventions. CalPERS surveyed 11 health plan vendors about tobacco cessation benefits they provide. One plan received a rating of "excellent," 2 were "very good," 4 were "good," 3 were "fair," and 1 was "poor."
- With support from CDHS/TCS and UC/TRDRP, the California Smokers' Helpline is conducting a study to compare the effects of different levels of behavioral treatment for smokers using pharmacotherapy.
- CDHS/TCS, CDE/HKPO, and UC/TRDRP are participating in The Next Generation Alliance's project to make cessation services a health insurance benefit in California.

Progress Toward Recommendation 8:
The Department of Alcoholic Beverage Control should incorporate compliance with the California Smoke-Free Workplace Act in decisions regarding bar license approvals, suspensions, and renewals.

There has been limited progress in implementing this recommendation. While there is a cooperative relationship

between ABC and tobacco control programs, in which ABC uses a uniform protocol to inspect establishments that serve alcohol and to note violations using a form with a check-off box about smoking, it does not act on this information. The ABC has not used its existing legal authority to implement this recommendation. TEROC urges the Governor to direct ABC to cooperate more fully with local law enforcement agencies to enforce the California Smoke-Free Workplace Act in bars.

Progress Toward Recommendation 9:

The California Children and Families State Commission should encourage local commissions to include objectives for tobacco control in their strategic plans.

CDHS/TCS has partnered on numerous occasions with the California Children and Families State Commission (CCFSC), including the CCFSC's $3 million augment of the California Smokers' Helpline to provide cessation services for families with children under the age of five. The CDHS/TCS Media Unit coordinates with CCFSC and the Helpline to ensure a consistent volume of callers, and to coordinate tobacco control messages, strategies, and targets. TEROC feels that CCFSC should have a significant role in tobacco control, and that so far it has not fulfilled the language of Proposition 10 and the intent of the proposition's voters.

Progress Toward Recommendation 10:

Continue to coordinate Proposition 99-financed programs with State, Federal, and other tobacco control initiatives.

TOBACCO CONTROL THROUGH THE ARTS

In January 2001, three tobacco control projects were funded by CDHS/TCS that focused on the arts.

Tobacco Games (San Diego Space and Science Foundation) *has three parts. A room-sized virtual reality game, "Smoke and Mirrors," allows six visitors at a time to have their faces scanned to project upon and inhabit a virtual human body. Players progress through scenes exposing tobacco advertising and product placement. Players' scanned faces are first "sucked in" to the game, and finally end up on an autopsy table being exhaled in a puff of smoke. There are also six online computer games.*

Smoke, Lies and Videotape ***(Hollywood Entertainment Museum)*** *is an interactive museum exhibit using sounds and images drawn from the history of the entertainment arts and the appearance of tobacco as a recurring theme. There is also an internet-based companion exhibit.*

TARNIVAL! Tobacco Education Through Science (Regents of the University of California) *uses street theater performances with giant puppet figures, actors, and performance artists. One character speaks only in words taken directly from tobacco industry documents. Linked to the street theater element is a "festival" with interactive education and research-based activity stations involving science, math, psychology, and a website.*

- All three agencies responsible for the administration of the Tobacco Control Program—CDHS/TCS, CDE/HKPO, and UC/TRDRP—continue to coordinate closely with each other and with numerous State, Federal, and other tobacco control initiatives such as:

  California Children and Families Commission, Department of Alcohol and Drug Programs/Center for Substance Abuse Prevention, Centers for Disease Control and Prevention/Office on Smoking and Health, the Campaign for Tobacco Free Kids, The California Attorney General, American Legacy Foundation, Next Generation Alliance, and Robert Wood Johnson Smokeless States Initiative.

- CDHS/TCS also collaborates with:

  Asian Pacific Partners for Empowerment and Leadership, Association of State and Territorial Health Officials, California Board of Equalization

- UC/TRDRP also collaborates with:

  National Organization of Tobacco Use Research Funders, National Cancer Institute/Tobacco Research Branch

- CDE/HKPO also collaborates with:

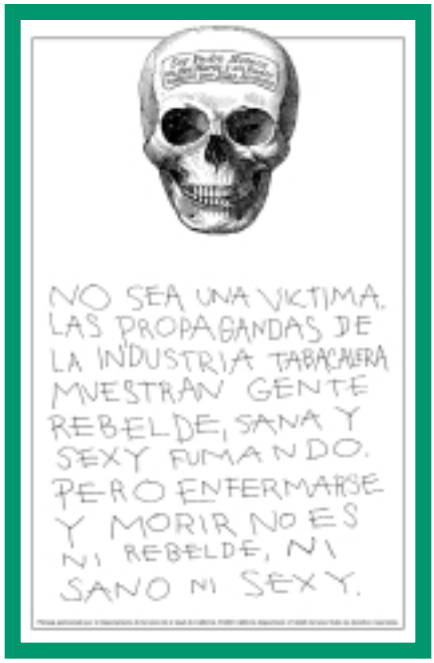
  Department of Alcohol and Drug Programs, Department of Health Services/Maternal and Child Care Division.

- The American Cancer Society's National Home Office collaborated with CDHS/TCS on the development of materials and training of Communities of Excellence (CX) in Tobacco Control.
- CDHS/TCS, the Attorney General's Office, and CDE/HKPO receive funding from the American Legacy Foundation to establish youth advocacy coalitions and conduct other youth-focused activities in California. Legacy also provided consultation to CDHS/TCS on the STORE Campaign.
- UC/TRDRP collaborates with CDE/HKPO on School-Academic Research Awards (SARAs). Four awards were made between 2000 and 2002. These projects are developing school-based anti-tobacco programs for deaf/hard of hearing youth; changing school norms around tobacco; using nicotine replacement in school-based cessation; and testing an internet virtual world for teen smoking counseling.
- UC/TRDRP encourages collaborations between researchers and community organizations through its Community-Academic Research Awards (CARAs). Five projects received funding between 2000 and 2002. Target audiences on these projects were Hmong, LGBT communities, older adults, Latinos, and the Bayview-Hunters Point community (primarily African American).
- UC/TRDRP has provided technical assistance and peer review on tobacco control research to other states (Minnesota, Colorado, Florida, Louisiana, Texas).
- CDHS/TCS has provided technical assistance on tobacco control to 49 states in the last three years.

Progress Toward Recommendation 11:

Settle the outstanding litigation left over from the previous Administration to increase funding for tobacco control efforts.

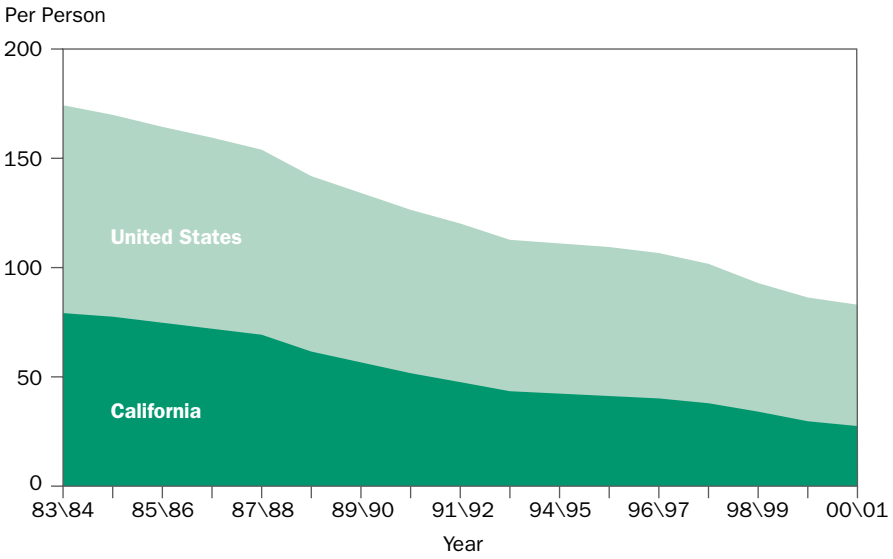
The funds remaining in the outstanding litigation accounts have been spent, and allocated for tobacco control purposes. In FY 2000-01, the Americans for Nonsmokers Rights (ANR) Restricted Reserve was used to augment the CDHS/TCS media campaign and to cover unanticipated declines in Prop 99 revenues.



(2001 Statewide Media Campaign)

Figure 3

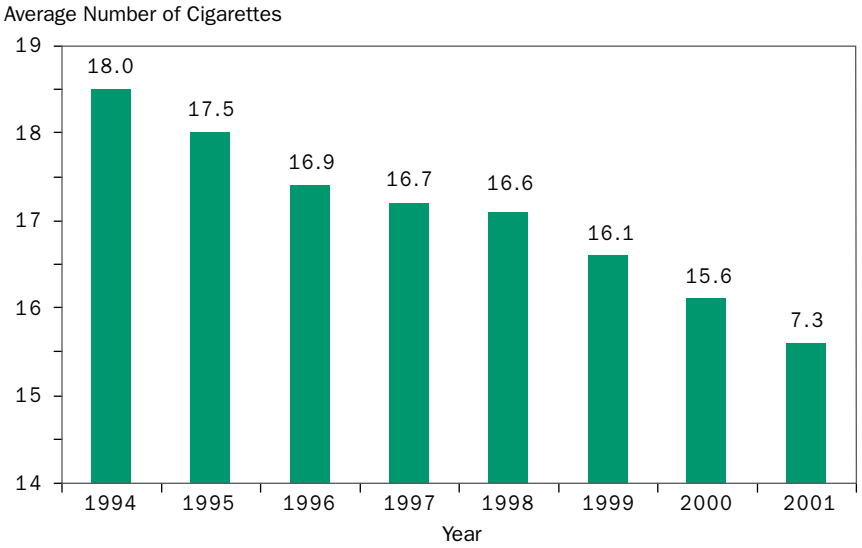
California and U.S. Adult per Capita Cigarette Consumption, Packs per Fiscal Year, 1983/1984 – 2000/2001



Source: California State Board of Equalization (packs sold) and California Department of Finance (population). U.S. Department of Agriculture. Note that CA data is by fiscal year (July 1 – June 30) and U.S. data is by calendar year. Prepared by: California Department of Health Services, Tobacco Control Section, October 2001.

Figure 4

Average Number of Cigarettes Smoked per Day by Everyday Smokers in California, 1994-2001



Source: CATS/BRFS 1994 – 2001, is weighted to the 1990 California population. Prepared by Tobacco Control Section, California Department of Health Services, 2002.

Consumption and Prevalence

Adult smoking prevalence in California has dropped at a rate that is faster than the nation, and youth smoking prevalence has also fallen. Per capita cigarette consumption has declined, and more people report being light smokers.

Adult Smoking

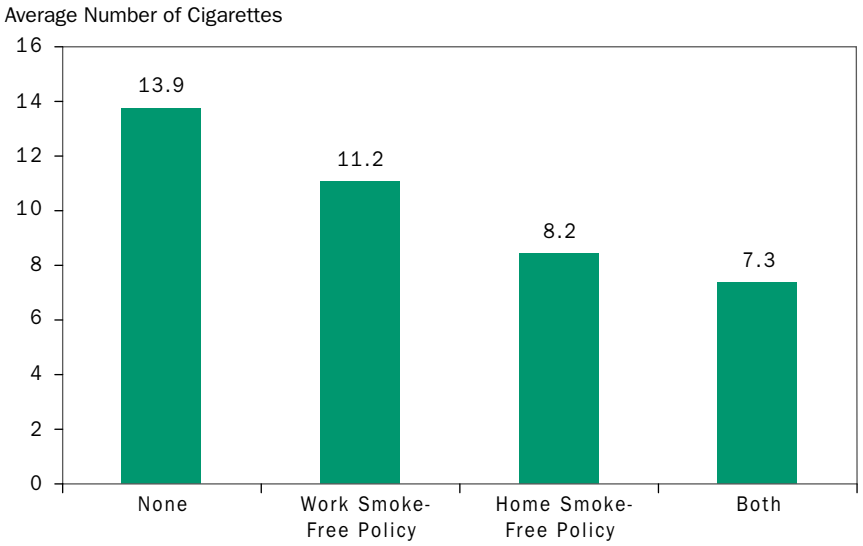
Cigarette Consumption. Since 1988, per capita cigarette consumption in California declined by 60%, as shown in Figure 3. During the same period, per capita consumption in the entire nation (including California) declined by 34%.

Declines in the average daily cigarette consumption reported by current smokers appear to be causing the dramatic declines in per capita consumption. Figure 4 shows that the average number of daily cigarettes was 18 per day in 1994, and 15.1 per day in 2001. This is a decrease of 16% over six years.

Furthermore, California smokers who report a lower average daily consumption of cigarettes are more likely to have a smoke-free work place and/or a smoke-free home, as shown in Figure 5.

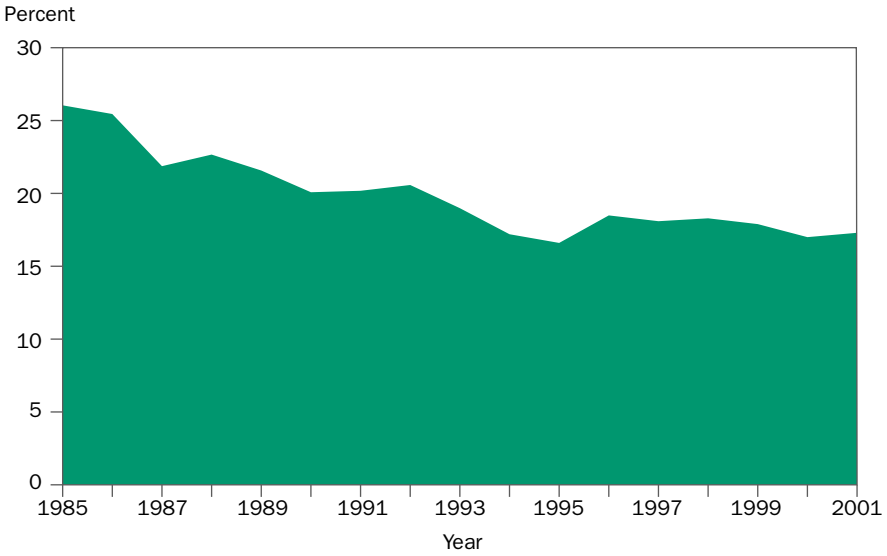
Smoking Prevalence. Since 1988, the adult smoking prevalence in California has declined significantly from 22.8% in 1988 to 17.4% in 20001,[11] as shown in Figure 6. This is a decrease of about 25%. Based on the 2000 adult population, there are approximately 4.2 million current adult smokers in California.

Figure 5
Average Number of Cigarettes Smoked per Day by Smoke-Free Policy, 1999



Source: CTS adult Extended Survey 1999, weighted to the 1996 California population. Prepared by: Tobacco Control Section, California Department of Health Services, 2001.

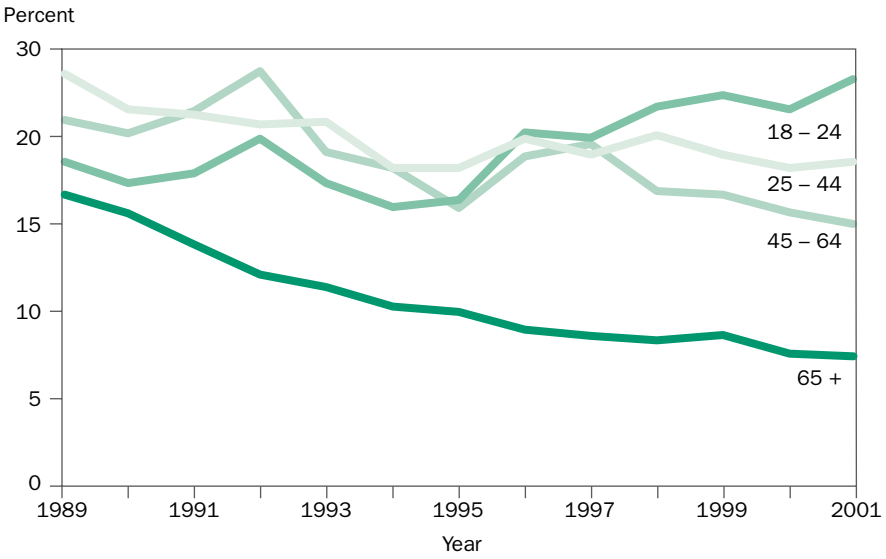
Figure 6
California Adult Smoking Prevalence, 1985–2001



Source: BRFS 1985–1992 CATS/BRFS, 1993–2001 is weighted to the 1990 California popluation. Note definitional change of smker in 1996 to include more occasional smokers. Prepared by: California Department of Health Services, Tobacco Control Section, 2002.

[11] *A revised smoker definition developed by the U.S. Centers for Disease Control and Prevention was used beginning in 1996. This resulted in the inclusion of more occasional smokers and thus raised prevalence estimates by 1-2 percentage points in 1996 and subsequent years.*

Figure 7
Smoking Prevalence among California Adults by Age Group, 1989–2001

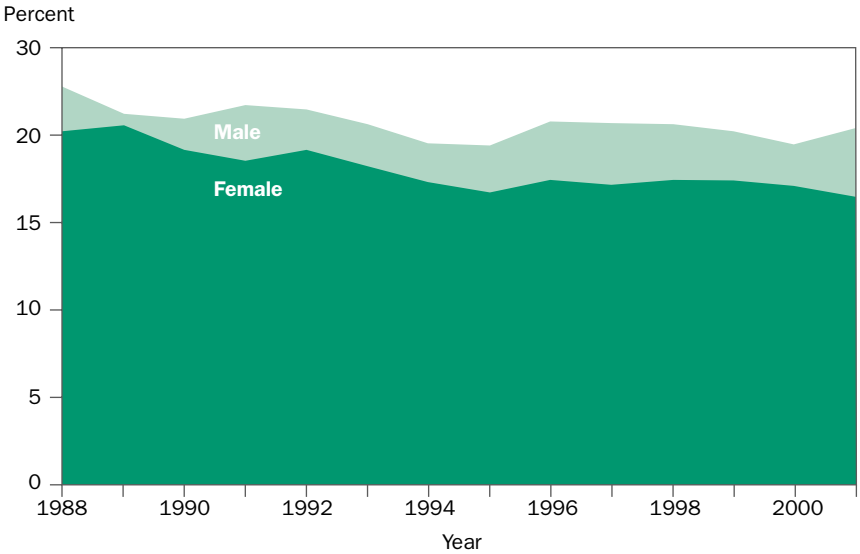


Source: BRFS 1985–1992 CATS/BRFS, 1993–2001 is weighted to the 1990 California popluation. Note definitional change of smker in 1996 to include more occasional smokers. Prepared by: California Department of Health Services, Tobacco Control Section, 2002.

There are some age differences in smoking prevalence, which can be clearly seen in Figure 7. After 1995, the 18-24 age group showed the greatest increase among the four groups, and is the only group with a trend that has continued to rise after 1998. The age group of 65 and older had the lowest prevalence and a declining trend throughout the 13-year period. Those between 45-64 declined from the highest smoking prevalence rates in 1989 to the second lowest in 2001.

Men have had consistently higher smoking prevalence rates than women, but rates for both have declined since 1988. The prevalence rates had similar trends from 1992 to 2000, and then diverged in 2001 (Figure 8).

Figure 8
Smoking Prevalence among California Adults by Gender, 1988–2001



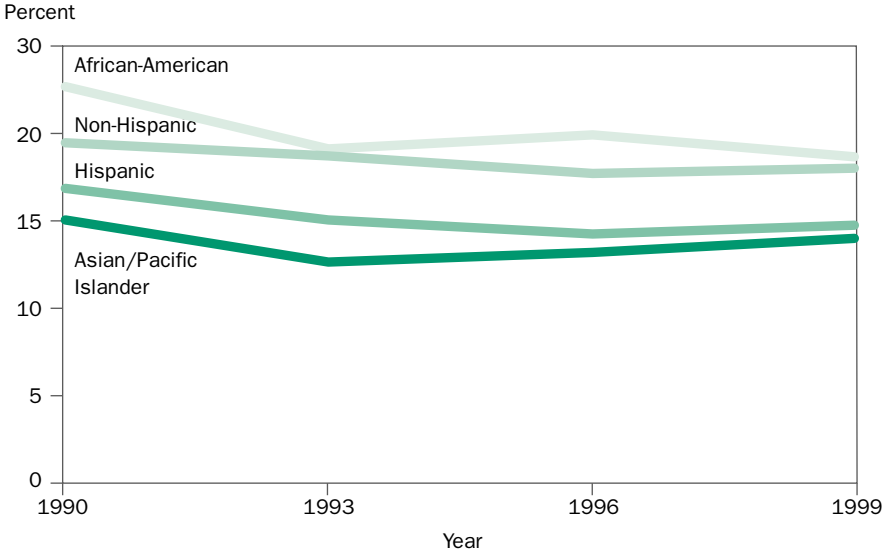
Source: BRFS 1988–1992 CATS/BRFS, 1993–2001 is weighted to the 1990 California popluation. Note definitional change of smker in 1996 to include more occasional smokers. Prepared by: California Department of Health Services, Tobacco Control Section, 2002.

Figure 9 shows smoking prevalence rates by race/ethnicity group. African Americans and Non-Hispanic Whites had the highest smoking prevalence rates, followed by Hispanics and Asians/Pacific Islanders. Smoking prevalence in all groups declined from 1990 to 1993, but remained relatively flat from 1993 to 1999. The greatest decline in prevalence occurred among African American women (23.9% in 1990 to 16.5% in 1999). Prevalence rates among Asian/Pacific Islander and Hispanic females were less than half the rates of their male counterparts.

Youth Smoking [12]

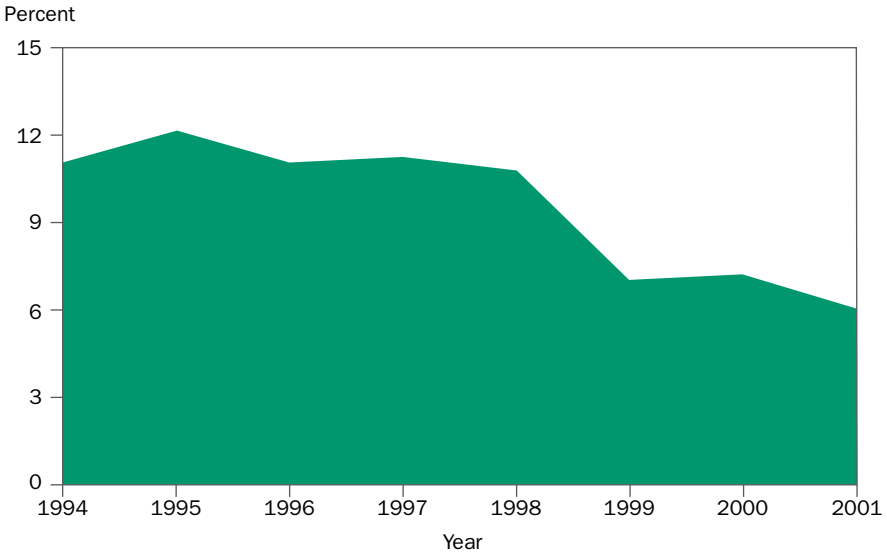
The prevalence of cigarette smoking among youth 12-17 years of age in California decreased from 11% in 1994 to 5.9% in 2001, as measured by the California Youth Tobacco Survey (CYTS). Overall, from 1994 to 2001, youth smoking prevalence declined 46% in California.

Figure 9
Age-adjusted Smoking Prevalence among California Adults by Race/Ethnicity Group, 1990–1999



Source: CTS, Screener Survey, 1990, 1993, 1996, and 1999 are weighted to the 1996 California population. Note definitional change of smoker in 1996 to include more occasional smokers. Prepared by: California Department of Health Services, Tobacco Control Section, 2002.

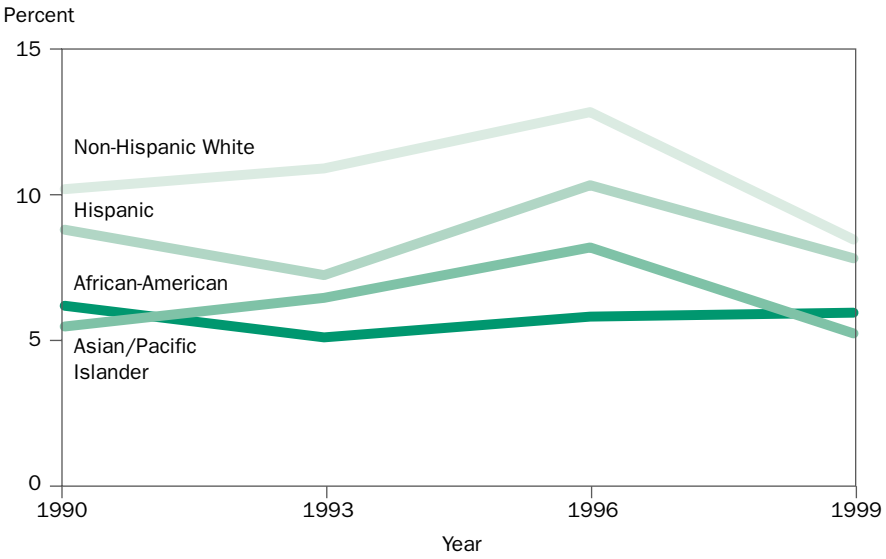
Figure 10
30-day Smoking Prevalence among California Youth, 1994–2001



Source: CYTS 1994–2001 is weighted to the 1990 California population. Prepared by: California Department of Health Services, Tobacco Control Section, 2002.

[12] *Data on youth smoking prevalence come from the California Youth Tobacco Survey (CYTS), conducted annually with 2,300 youth (aged 12-17) by the Cancer Surveillance Section of the CDHS; and from the California Tobacco Surveys (CTS) conducted annually by the Cancer Prevention and Control Program of the University of California, San Diego.*

Figure 11
30-day Smoking Prevalence among California Youth by Race Group, 1990–1999



Source: CTS, 1990, 1993, 1996, and 1999 are weighted to the 1996 California population. Prepared by: California Department of Health Services, Tobacco Control Section, 2001.

Non-Hispanic White youth aged 12-17 had the highest smoking prevalence among the four largest racial/ethnic groups. African American and Asian youth had the lowest smoking prevalence. Smoking prevalence among youth in all groups except African Americans increased from 1990 to 1996, and then declined significantly from 1996 to 1999 among Asian, Hispanic, and non-Hispanic White youth populations. Figure 11 shows prevalence rates by race/ethnic group. From 1994 to 2001, youth smoking rates in California did not differ significantly by gender.

Health Benefits from Cessation

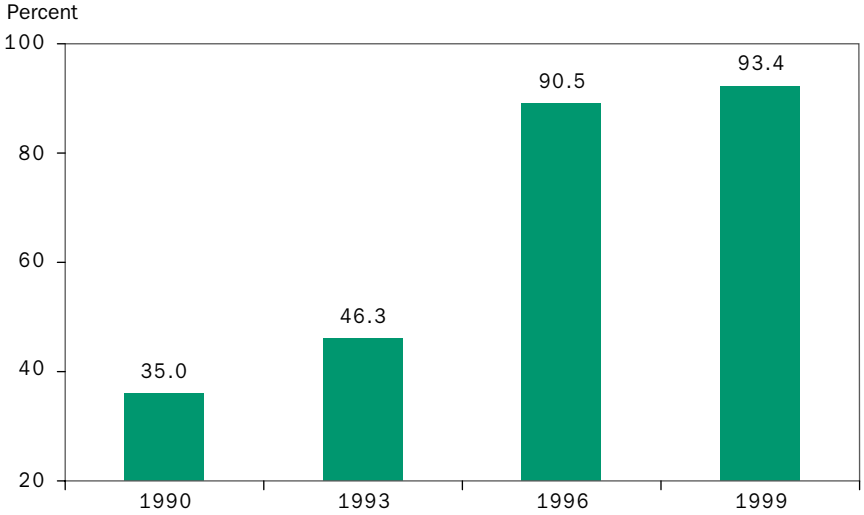
The reduction in tobacco consumption has led to immediate health benefits for the California population. For example, smoking cessation produces almost immediate reductions in heart attacks and strokes (Lightwood and Glantz 1997) and low birth weigh infants (Lightwood, Phibbs, and Glantz 1999). The California Tobacco Control Program was associated with 58,900 fewer deaths from heart disease between 1989 and 1997 than would have been expected without the program (Fichtenberg and Glantz 2000).

According to the California Cancer Registry, lung and bronchus cancer rates in California declined 14.4% between 1988 and 1996, compared with a decrease in SEER[13] regions of only 4%. While women in California experienced a decrease in lung cancer incidence of 6.7%, women in other SEER regions experienced an increase of 9.3%.

[13] *Surveillance, Epidemiology, End Results (SEER) registries in Connecticut, Detroit, Hawaii, Iowa, New Mexico, Seattle, Utah, and Atlanta were compared with the California Cancer Registry for this analysis.*

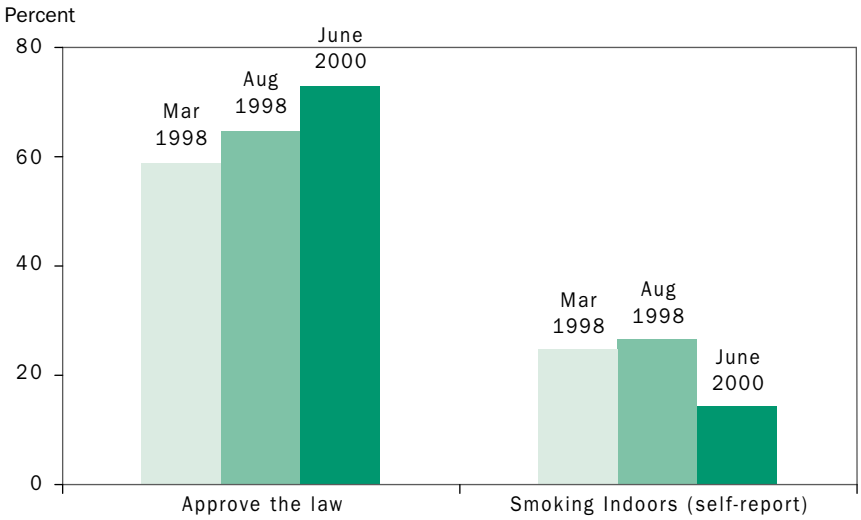
(2001 Statewide Media Campaign)

Figure 12
Proportion of California Indoor Workers Who Have a Smoke-Free Workplace, 1990–1999



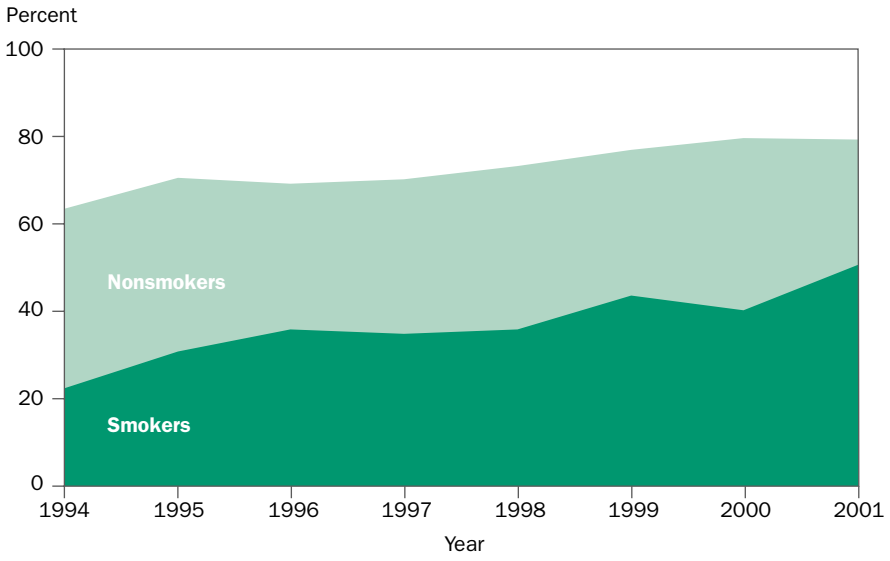
Source: CTS Adult Extended Survey 1990, 1993, and 1999, weighted to the 1996 California population. Prepared by: California Department of Health Services, Tobacco Control Section, 2001.

Figure 13
California Bar Patrons' Approval of and Compliance with the State's Smoke-Free Bar Law, 1998–2000



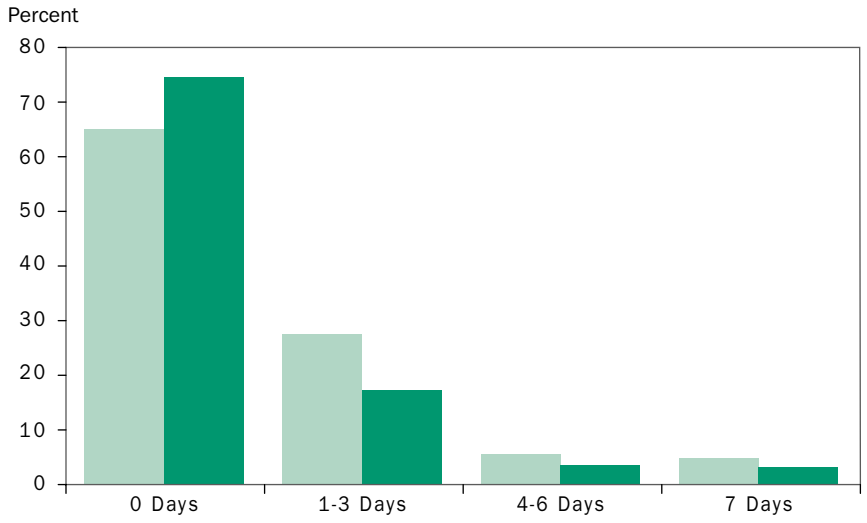
Source: California Smoke-Free Bar Field Polls, March 1998, August 1998, and June/July 2000. Prepared by: California Department of Health Services, Tobacco Control Section, 2001.

Figure 14
Proportion of Californians Who Prohibit Smoking in Their Home, 1994–2001



Source: CATS 1993–2001, weighted to the 1990 California population. Prepared by: California Department of Health Services, Tobacco Control Section, 2002.

Figure 15
Proportion of California Youth Who Are Exposed to Secondhand Smoke, 2001



Source: CYTS 2001, weighted to the 1990 California population. Prepared by: California Department of Health Services, Tobacco Control Section, 2002.

Secondhand Smoke

Considerable progress has been made toward creating a smoke-free environment through legislation, enforcement, and voluntary policies that restrict where smoking may occur.

Between 1990 and 1999, the proportion of those working indoors who have a smoke-free workplace rose from 35% to nearly 94%, as shown in Figure 12.

Support for — and compliance with — California's smoke-free bar law is also increasing, as shown in Figure 13.

Increasing numbers of families — including nonsmokers and smokers — have a no-smoking policy for their homes (Figure 14). The effect of these policies on youth is evident in Figure 15, which shows that fewer youth are being exposed to secondhand smoke indoors and in cars.

References

American Legacy Foundation (2002). *Saving lives, saving money: Why states should invest in a tobacco-free future.* Washington, DC: American Legacy Foundation.

Bitton, A., Fichtenberg, C., and Glantz, S. (2001). Reducing smoking prevalence to 10% in five years. *MSJAMA, 286* (21), 2733-2734.

California Healthy Cities and Communities (2000). *Developing youth and community through tobacco prevention.* Sacramento, CA: California Department of Health Services.

Campaign for Tobacco Free Kids (2002). *Show us the money: An update on the states' allocation of the tobacco settlement dollars.* www.tobaccofreekids.com

Centers for Disease Control and Prevention (1999). *Best practices for comprehensive tobacco control programs.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office of Smoking and Health.

Chaloupka, F.J. and Pacula, R.L. (2001). The impact of price on youth tobacco use. In National Cancer Institute, *Changing adolescent smoking prevalence. Smoking and Tobacco Control Monograph No. 14.* Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute, NIH Pub. No. 02-5086, 193-199.

Chen, X., Cruz, T.E., Schuster, D.V., Unger, J.B., and Johnson, C.A. (2002). Receptivity to pro-tobacco media and its impact on cigarette smoking among ethnic minority youth in California. *Journal of Health Communication, 7,* 95-111.

Coller, M., Harrison, G.W., and McInnes, M.M. (2002). Evaluating the tobacco settlement damage awards: Too much or not enough? *American Journal of Public Health, 92* (6), 984-989.

Department of Health Services, Tobacco Control Section (1998). *A model for change: The California experience in tobacco control.* Sacramento, CA: California Department of Health Services.

Edwards, C.C., Elder, J.P., de Moor, C., Wildey, M.B., Mayer, J.A., and Senn, K.L. (1992). Predictors of participation in a school-based anti-tobacco activism program. *Journal of Community Health, 17*, 283-289.

Ellis, J. (2002). Tobacco and the media. *American Journal of Public Health, 92* (6), 895.

Farrelly, M.D., Healton, C.G., Davis, K.C., Messeri, P., Hersey, J.C., and Haviland, M. L. (2002). Getting to the truth: Evaluating national tobacco countermarketing campaigns. *American Journal of Public Health, 92* (6), 901-907.

Fichtenberg, C.M. and Glantz, S.A. (2000). Association of the California Tobacco Control Program with declines in cigarette consumption and mortality from heart disease. *New England Journal of Medicine, 343* (24), 1172-1777.

Gilpin, E.A., Farkas, A.J., Emery, S.L., Ake, C.F., and Pierce, J.P. (2002). Clean indoor air: Advances in California, 1990-1999. *American Journal of Public Health, 92* (5), 785-791.

Gilpin, E.A., Emery, S.L., Farkas, A.J., Distefan, J.M., White, M.M., and Pierce, J.P. (2001) *The California Tobacco Control Program: A decade of progress, results from the California tobacco surveys, 1990-1998.* La Jolla, CA: University of California, San Diego.

Glantz, S. (2002). *www.smokefreemovies.ucsf.edu.*

Gross, C.P., Soffer, B., Bach, P.B., Rajkumar, R. and Forman, H.P. (2002). State expenditures for tobacco-control programs and the tobacco settlement. *New England Journal of Medicine, 347* (14), 1080-1086.

Harris, D. (2001). Corporate goodwill or tainted money? Philip Morris' charitable contributions, ad campaign seen as smoke-screen. ABC News.com. February 8, 2001.

Independent Evaluation Consortium (2001). *Interim report: Independent evaluation of the California Tobacco Control Prevention and Education Program: Wave 2 data, 1998; Wave 1 and Wave 2 data comparisons, 1996-1998.* Rockville, MD: The Gallup Organization.

Landman, A., Ling, P.M., and Glantz, S.A. (2002). Tobacco industry youth smoking prevention programs: Protecting the industry and hurting tobacco control. *American Journal of Public Health, 92* (6), 917-930.

Lightwood, J.M. and Glantz, S.A. (1997). Short-term economic and health benefits of smoking cessation: Myocardial infarction and stroke. *Circulation, 96* (4), 1089-1096.

Lightwood, J.M., Phibbs, C., and Glantz, S.A. (1999). Short-term health and economic benefits of smoking cessation: Low birth weight. *Pediatrics, 104,* 1312-1320.

Malone, R.E. (2002). Tobacco industry surveillance of public health groups: The case of STAT and INFACT. *American Journal of Public Health, 92* (6), 955-960.

Max, W., Rice, D.P., Zhang, X., Sung, H. and Miller, L. (2002). *The cost of smoking in California, 1999.* Sacramento, CA: California Department of Health Services.

Ng, C. and Dakake, B. (2002). *Tobacco at the movies: Tobacco use in PG-13 films.* Boston: Massachusetts Public Interest Research Group.

Parmley, W. and Glantz, S.A. (1991). Passive smoking and heart disease: Epidemiology, physiology, and biochemistry. *Circulation, 83* (1), 1-12.

Rohrbach, L.A., Howard-Pitney, B., Unger, J.B., Dent, C.W., Howard, K.A., Cruz, T.B., Ribisi, K.M., Norman, G.J., Fishbein, H., and Johnson, C.A. (2002). Independent evaluation of the California Tobacco Control Program: Relationships between program exposure and outcomes, 1996-1998. *American Journal of Public Health, 92* (6), 975-983.

U.S. Department of Health and Human Services (1998). *Tobacco use among U.S. racial/ethnic minority groups — African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A report of the Surgeon General.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

U.S. House of Representatives, Minority Staff Report, Special Investigations Division, Committee on Government Reform. (September 17, 2002). Tobacco industry statements in the Department of Justice lawsuit [On-line]. Available: http://www.house.gov/reform/min/inves_tobacco/index_doj.htm.

Wakefield, M. and Chaloupka, F. (2000). Effectiveness of comprehensive tobacco control programmes in reducing teenage smoking in the USA. *Tobacco Control, 9*, 177.

Wakefield, M.A., Terry-McElrath, Y.M., Chaloupka, F.J., Barker, D.C., Slater, S.J., Clark, P.I., and Giovino, G.A. (2002). Tobacco industry marketing at point of purchase after the 1998 MSA billboard advertising ban. *American Journal of Public Health, 92* (6), 937-940.

Warner, K.E. (2002). What's a cigarette company to do? *American Journal of Public Health, 92* (6), 897-900.

Zhang, X., Miller, L., Max, W., and Rice, D.P. (1999). Cost of smoking to the Medicare Program, 1993. *Health Care Financing Review, 20* (4), 179-196.

Appendix

History and Background of the California Tobacco Control Program

In November 1988, California voters approved the historic ballot initiative called Proposition 99 that increased the tax on each pack of cigarettes sold in California by 25 cents, effective January 1, 1989. With the passage of Prop 99 — the Tobacco Tax and Health Protection Act of 1988 — the people of California created a comprehensive program to address the devastating and costly toll of tobacco use on the health of Californians.

Prop 99 established the Cigarette and Tobacco Products Surtax Fund, and specified that the funds would be spent for: **Health Education** (20% for community and school-based tobacco education and prevention programs); **Research** (5% for research on tobacco-related diseases); **Hospital Services** (35% for treatment of medically indigent hospital patients); **Physician Services** (10% for treatment of medically indigent patients by physicians); **Public Resources** (5% for the protection of wildlife habitat and programs to enhance park and recreation resources); and **Unallocated** (25% to be distributed by the Legislature to any of the other accounts).

The Tobacco Control Program was launched in the Spring of 1990 with funds from the **Health Education and Research Accounts**. It became the largest tobacco control program in the world, and is now an internationally recognized model of statewide tobacco control. Oversight of the programs funded by the Health Education and Research Accounts is carried out by the Tobacco Education and Research Oversight Committee (TEROC), whose members are appointed by the Governor, the Legislature, and the Superintendent of Public Instruction.

The Tobacco Control Section (TCS) of the California Department of Health Services (CDHS) administers the public health aspects of the program. This network includes 61 local health departments, four ethnic networks, 11 regional community linkage projects, approximately 100 community-based organizations, a statewide media campaign, and other statewide support systems.

California's strategy is to create a social milieu and legal climate in which tobacco use is regarded as unacceptable — to denormalize smoking and other tobacco use. This "social norm" approach engages everyone — smokers and nonsmokers alike.

The community-based component of the Tobacco Control Program has four broad priority areas:

- Eliminate exposure to secondhand smoke
- Counter pro-tobacco influences
- Reduce the marketing and illegal sale of tobacco to youth
- Provide cessation services

The Program's media campaign promotes three core messages that are reinforced by local program activities:

- The tobacco industry lies
- Secondhand smoke kills
- Nicotine is addictive

The Healthy Kids Program Office (HKPO) of the California Department of Education (CDE) administers the school-based component of the program, which involves 58 county offices of education and nearly 1,000 school districts. The school-based component of the program seeks to reduce the use of tobacco by youth by providing students with information and skills to help them resist the tobacco industry.

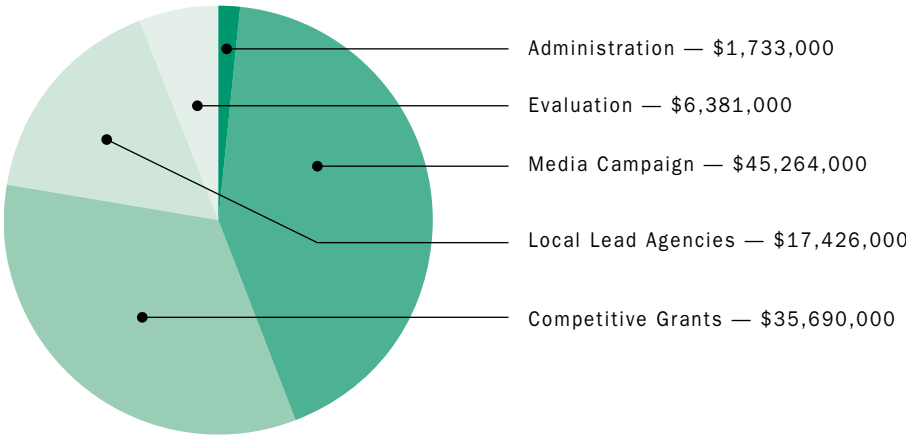
The University of California (UC) administers the Tobacco-Related Disease Research Program (TRDRP) with funds from the Research Account. UC/TRDRP

funds research that leads to improved approaches to the prevention, diagnosis, and treatment of tobacco-related illness and to increasing the effectiveness of the California Tobacco Control Program. The goals of the research component of the Program are to enhance understanding of tobacco use and tobacco-related diseases, and to develop more effective interventions for their prevention and treatment.

Figures 16, 17, and 18 display the comparative budget allocations for Fiscal Year 2001-2002 for CDHS/TCS, CDE/HKPO, and UC/TRDRP, by program component.

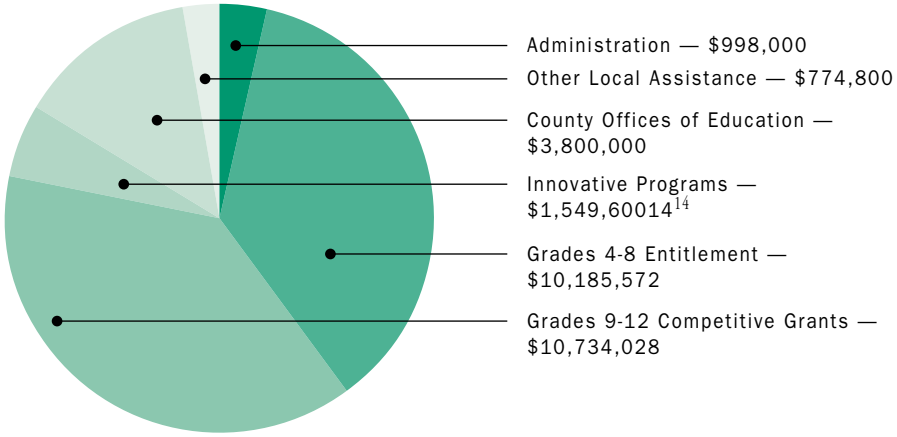
The activities of these three institutions together create a statewide coordinated, comprehensive program that has changed social norms toward a smoke-free California.

Figure 16
Tobacco Control Section Funding Components, California Department of Health Services, 2001-2002



TOTAL — $106,494,000

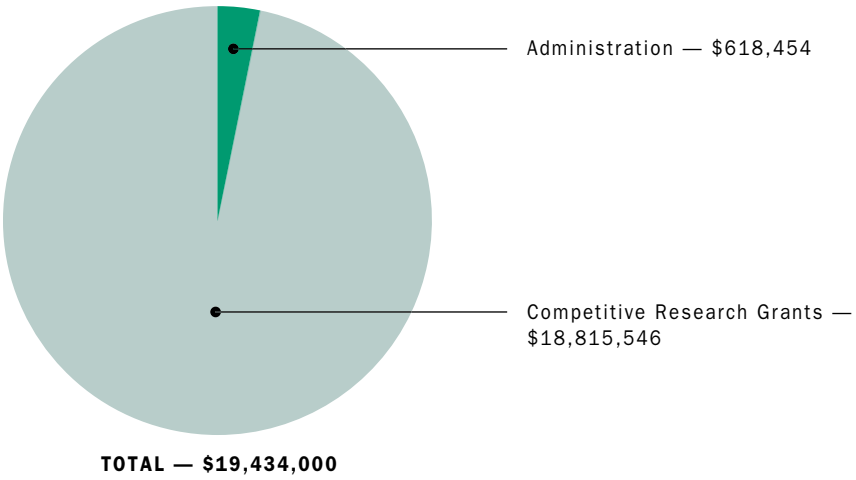
Figure 17
Tobacco Use Prevention Education Funding Components, California Department of Education, 2001-2002



TOTAL — $28,042,000

[14] *$200,000 of this figure is allocated to Indian Education Centers.*

Figure 18
Tobacco-Related Disease Research Program Funding Components, University of California, 2001-2002



The California Tobacco Education and Research Oversight Committee (TEROC)

TEROC is a statutorily-mandated committee that provides oversight and advice regarding California's education and research programs. TEROC set the tone for the California Tobacco Control Program in its first Master Plan (1991) by emphasizing in its recommendations that "no tobacco use should be the societal norm" in California. In 1992, TEROC fought to recover the full 20% of the Proposition 99 revenues earmarked for tobacco education purposes and the full 5% earmarked for tobacco-related disease research when the State Legislature attempted to divert those funds to other programs. That same year, TEROC succeeded in persuading the Tobacco-Related Disease Research Program (TRDRP) to fund more behavioral and policy research that could provide results that would help applied tobacco control efforts.

TEROC repeatedly fought to protect the funding of these programs, urging program re-authorization and full funding in 1991, 1993, and 1996. TEROC helped the successful effort in 1996 to eliminate program authorization sunset language and shift program funding into the annual State budget process. Beginning in 1999, TEROC supported efforts to secure additional funding for these programs from court settlement payments to the State from the tobacco companies. TEROC also stood guard against political interference with the tobacco control statewide media campaign, and succeeded in leading the constituency to pressure the Administration to stop the campaign from referring to the "tobacco industry," and from having messages that say that the tobacco industry is deceptive.

¡PELIGRO DE MUERTE!
No sea la próxima víctima del tabaco.
Mensaje pagado por el Departamento de Servicios de Salud de California. ©2001 California Department of Health Services. Todos los derechos reservados.

Notes