S. Hrg. 101-1117

HEALTH IMPACT, COSTS OF SMOKING

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

MAY 24, 1990

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

35-777 WASHINGTON : 1991

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

S361-15

COMMITTEE ON FINANCE

LLOYD BENTSEN, Texas, *Chairman*

DANIEL PATRICK MOYNIHAN, New York
MAX BAUCUS, Montana
DAVID L. BOREN, Oklahoma
BILL BRADLEY, New Jersey
GEORGE J. MITCHELL, Maine
DAVID PRYOR, Arkansas
DONALD W. RIEGLE, Jr., Michigan
JOHN D. ROCKEFELLER IV, West Virginia
TOM DASCHLE, South Dakota
JOHN BREAUX, Louisiana

BOB PACKWOOD, Oregon
BOB DOLE, Kansas
WILLIAM V. ROTH, Jr., Delaware
JOHN C. DANFORTH, Missouri
JOHN H. CHAFEE, Rhode Island
JOHN HEINZ, Pennsylvania
DAVID DURENBERGER, Minnesota
WILLIAM L. ARMSTRONG, Colorado
STEVE SYMMS, Idaho

VANDA B. MCMURTRY, *Staff Director and Chief Counsel*
EDMUND J. MIHALSKI, *Minority Chief of Staff*

CONTENTS

OPENING STATEMENTS

Page

Bentsen, Hon. Lloyd, a U.S. Senator from Texas, chairman, Senate Finance Committee 1
Breaux, Hon. John, a U.S. Senator from Louisiana 13
Daschle, Hon. Thomas A., a U.S. Senator from South Dakota 15
Symms, Hon. Steve, a U.S. Senator from Idaho 27

COMMITTEE PRESS RELEASE

Senator Bentsen Announces Hearing on the Health Impact, Costs of Smoking; Effects on Children to be Spotlighted 1

ADMINISTRATION WITNESS

Sullivan, Hon. Louis W., Secretary, U.S. Department of Health and Human Services 6

CONGRESSIONAL WITNESS

Lautenberg, Hon. Frank, a U.S. Senator from New Jersey 3

PUBLIC WITNESSES

Klein, Jonathan D., M.D., pediatrician, University of North Carolina at Chapel Hill, Chapel Hill, NC 16
Whitley, Charles O., senior consultant, The Tobacco Institute, Washington, DC, accompanied by Larry C. Holcomb, Ph.D., environmental toxicologist 18
Oates, John, M.D., professor of medicine and chairman, department of medicine, Vanderbilt University, Nashville, TN 21
Bristow, Lonnie R., M.D., member, board of trustees, American Medical Association, San Pablo, CA, accompanied by Michael Zarski, division of legislative activities 37
Tollison, Robert D., Ph.D., Duncan Black professor of economics, and director, Center for Study of Public Choice, George Mason University, Fairfax, VA 39
Myers, Robert J., former Chief Actuary, Social Security Administration, and chairman, Commission of Railroad Retirement Reform, Silver Spring, MD 40

ALPHABETICAL LISTING AND APPENDIX MATERIAL SUBMITTED

Bentsen, Hon. Lloyd:
Opening statement 1
Breaux, Hon. John:
Opening statement 13
Bristow, Lonnie R.:
Testimony 37
Prepared statement 45
AMA "Kids Against Tobacco," fact sheet on smoking 48
Daschle, Hon. Thomas A.:
Opening statement 15
Klein, Jonathan D.:
Testimony 16
Prepared statement with attachment 64
Lautenberg, Hon. Frank:
Testimony 3
Prepared statement 73

Page

Myers, Robert J.:
- Testimony 40
- Prepared statement with attachment 74

Oates, John:
- Testimony 21
- Prepared statement with exhibits 83

Sullivan, Hon. Louis W.:
- Testimony 6
- Prepared statement 103
- "Youth Access to Cigarettes," Inspector General's report, May 1990 107
- Model Sale of Tobacco Products to Minors Control Act 124

Symms, Hon. Steve:
- Opening statement 27

Tollison, Robert D.:
- Testimony 39
- Prepared statement 126

Whitley, Charles O.:
- Testimony 18
- Prepared statement 130
- "A Constitutional Analysis of Proposals to Disallow Tax Deductions for Tobacco Product Advertising Expenses, legal memorandum prepared by Covington & Burling 133
- Statements of:
  - Larry C. Holcomb, Holcomb Environmental Services 161
  - Jolly Ann Davidson, national spokesperson, The Tobacco Institute's Responsible Living Program 164
  - James A. Will, professor, University of Wisconsin 165

COMMUNICATIONS

American Public Health Association 184
National Chamber Foundation 186
Southern Legislative Conference 198
Worth, Mimi 191

HEALTH IMPACT, COSTS OF SMOKING

THURSDAY, MAY 24, 1990

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:13 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Bradley, Daschle, Breaux, and Symms.

[The press release announcing the hearing follows:]

[Press Release No H-33, May 10, 1990]

SENATOR BENTSEN ANNOUNCES HEARING ON THE HEALTH IMPACT, COSTS OF SMOKING; EFFECTS ON CHILDREN TO BE SPOTLIGHTED

WASHINGTON, DC—Senator Lloyd Bentsen, Chairman of the Senate Finance Committee, announced Thursday that the Committee will hold a hearing on the effects of smoking, including how it affects children.

Senator Bentsen (D., Texas) said the hearing will be at 10 a.m. on *Thursday, May 24, 1990* in Room SD-215 of the Dirksen Senate Office Building.

Secretary of Health and Human Services Louis Sullivan, M.D., will testify at the hearing.

Senator Bentsen said the hearing will explore data on the health impact and costs associated with smoking.

"The decision of whether or not to smoke is a personal one, but it should be made by adults and with a clear understanding of how smoking affects one's health. Unfortunately, though, a lot of children have no choice at all—or they make uninformed decisions," Bentsen said.

"When a woman smokes while pregnant, studies show there is an increased risk of miscarriage, premature birth, cerebral palsy and Sudden Infant Death Syndrome. Children who are born healthy but are exposed to passive smoke from their parents' cigarettes, cigars or pipes are at greater risk of contracting respiratory illnesses than children whose parents do not smoke. Further, more than half of all smokers started before they turned 15, when they were too young to understand the risks associated with that decision," Bentsen said.

"This hearing will provide Senators with some important information about the monetary and social costs of smoking, particularly the impact on Americans' health, and we'll explore alternative approaches to help discourage young people from starting to smoke and encourage people who already smoke to quit," Bentsen said.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, SENATE FINANCE COMMITTEE

The CHAIRMAN. We have a series of votes that will be cast this morning and a vote under way at the moment. So you will have quite a number of the members that will be showing up for the hearing as soon as that vote is finished.

In 1964 the U.S. Surgeon General, Luther Terry, issued a watershed report in which the Federal Government for the first time stated there was a definite link between smoking and lung cancer.

I remember that very well because that's the year I put out my last cigarette. In the years since, medical science has established more than a link. Read the warning label on a pack of cigarettes. "Smoking causes lung cancer, heart disease, emphysema, and may complicate pregnancy."

Now that warning is reenforced by studies—it seems like there's a new one every month—reminding us that smoking is bad for our health, even if we do not smoke. One recent study concluded that men who do not smoke live nearly 18 years longer than men who smoke cigarettes throughout their lives—18 years.

People know a lot more today about the dangers of smoking, but there are still a lot of people smoking. The smoking rate remains greater among minorities, blue collar workers, and some less educated Americans. Even though nearly one-half of all living Americans who have ever smoked have quit, Surgeon General Koop reported in 1989 that smoking still accounts for one in six deaths in this country.

In the time it takes to conduct this hearing almost 100 Americans will die of cancer, heart disease, emphysema and other ailments linked to smoking. Now smoking is a matter of choice, but it certainly ought to be an informed choice. People should understand the consequences of what they are doing.

When you get a "Don't Walk" sign at a busy intersection and have it flashing and you step off the curb anyway, you take a chance on getting run over by a truck. But with smoking there's not a Mack truck that people can see rolling down the street. So they may not appreciate the damage that smoking can do or they may be too young to worry about the long-term effects.

A decision to smoke affects more than one person. My longstanding efforts to improve children's health makes me especially concerned about smoking around them and what it does to them. Women who smoke while pregnant are more likely to have miscarriages. Their babies are more likely to be born prematurely at low weight. They are more likely to die from sudden death syndrome.

Young boys and girls whose parents smoke cigarettes, cigars or pipes at home and in the car are more likely to suffer from lung problems, other illnesses. Even though they are told that smoking is dangerous, 40 percent of children experiment with smoking in grade school. As I recall, mine was a grape vine.

The cost to one's health and family are sad enough. As members of the Finance Committee we also must deal with the costs of smoke-related illnesses to public programs. The Office of Technology Assessment estimated that treating people over age 65 for just three diseases that are related to smoking costs the Federal Government—the Federal health programs, and that's the taxpayers—up to $7 billion in 1985. Smoke-related illnesses accounted for as much as $35 billion in overall health care expenditures.

The Department of Health and Human Services has estimated that smoke-related illnesses cause about $52 billion in direct and indirect economic costs each year. That's about $221 for every man, woman, and child in America.

During today's hearing I want to establish the facts about the dangers of smoking. I'm looking forward to hearing my colleague, Senator Lautenberg, and to hearing Dr. Sullivan and other wit-

nesses tell us more about the health effects of smoking, particularly on children, about what it costs in Federal health programs, about ways to prevent people from smoking or help them quit; and thereby curtail avoidable costs, illnesses, and death.

We are very pleased to have a leader in this fight, one who has expended a great deal of effort and exerted substantial influence in helping mold public opinion, the distinguished Senator from New Jersey, Senator Lautenberg.

STATEMENT OF HON. FRANK LAUTENBERG, A U.S. SENATOR FROM NEW JERSEY

Senator LAUTENBERG. Thank you very much, Mr. Chairman. I commend you for holding this hearing. Thank you for the chance to testify. Those of us who know you are not surprised when we hear one of your wise decisions and you elected to stop smoking, you say, as soon as you heard about the dangers. It took me a few years beyond that. I wasn't quite as smart, but I am proud of the fact that I quit over 20 years ago, urged on by my children who professed love for me and did not want to see me, they said, out of the picture. So that took care of that for me.

Mr. Chairman, I know that part of the mission of your committee is to address pressing health care issues. I commend you for focusing this hearing on smoking and health. This is one of the principal problems plaguing our society. The cost to the health care system for tobacco-addicted Americans is enormous. You said in your own remarks that there was a cost of $7 billion directly to government.

We've heard that each year cigarette smoking costs our economy $65 billion in health care costs and lost productivity. Cigarette smoking costs the Medicaid and Medicare programs substantial sums. It impacts on private health insurance plans. The need to look at the impact of smoking on health care costs could not be greater; and the place to begin is with an examination of this issue concerning our young people.

If we can prevent our youngsters from getting hooked on tobacco products, we can save countless lives and billions of dollars in health care costs for the American people down the road. Right now, unfortunately, we're losing the battle to prevent our kids from taking up smoking.

The facts speak for themselves. According to the Surgeon General's 1989 report approximately 80 percent of those who smoke started before the age of 21. One out of four high school seniors who has ever smoked began when he was 12 years old. The earlier young person begins using tobacco, the harder it is for them to kick the habit.

As more and more people quit smoking, the tobacco industry has stooped lower and lower in order to keep the cash register ringing. Just to replace those smokers who have quit, the tobacco industry needs to hook 6,000 new smokers a day according to the Coalition on Smoking OR Health.

Where does the industry turn for its profits? It turns to the disadvantaged and to the minorities. Uptown, the cigarette the industry planned to test market to blacks in Philadelphia was among

the most blatant of its racial appeals. The industry turned its guns then on female teenagers. Dakota is the kind of product they would sell. And the most reprehensible of all, the industry has targeted our kids.

The tobacco industry says it does not want kids to smoke. It says it does not try to lure minors into a life time of smoking. But the tobacco industry's actions are just the opposite of what it purports are its aims. The tobacco industry's voluntary code says the industry will not use sports or celebrity testimonials that have a special appeal to persons under 21 years old.

Yet the industry continues to sponsor the Virginia Slims Tennis Tournament, the Marlboro Grand Prix, and other sporting events that attract millions of young people. It continues to hope that young viewers will see their athletics heroes and tobacco company logos side-by-side on the TV screen. I notice that we have a poster here that reflects that kind of glamorous image.

The tobacco industry's voluntary code says, "Cigarette advertising will not suggest that smoking is essential to social prominence, distinction, success or sexual attraction and that it will not picture a person smoking in an exaggerated manner." But cigarette ads suggest all of these things, like these recent Camel ads in Sports Illustrated and People Magazine.

We have the Camel cigarette, this very attractive young lady, sailboat, airplane, all of those things. It's the same with this magazine thing, only here they're playing pool in very elegant regalia, I must say, for a pool hall. And here they sell cigarettes—candy in cigarette packets. Well these are not designed to attract adults as I see it. Maybe some that we know, but not all certainly.

These are the kinds of things that we continue to see. Their voluntary code, the industry's voluntary code, says free cigarette samples will not be given to any person who is known to be younger than 21.

Yet, minors receive advertisements in the mail that offer them free packs of cigarettes. Young people are approached on the street and offered free cigarette samples. The tobacco industry tries to lure our young people into smoking with all kinds of flashy gimmicks. It gives away free T-shirts that appeal to young people; it gives away cartoon posters that appeal to young people. Tobacco companies do not mind having their brand names ripped off to sell candy cigarettes to adolescents.

Mr. Chairman, for too long our government has been complacent about the numbers of young people that are taking up smoking. For too long it sat on the sidelines and watched tobacco products slowly suck the life out of our citizens. We cannot sit by idly any longer while tobacco companies cynically devise marketing campaigns to lure our most vulnerable, particularly our young people, into a life of nicotine addiction. We need to fight back.

In many ways the fight against tobacco addiction among our young people is like the fight against drug addiction. Drugs are addictive. But tobacco may be even more so. Drugs are fatal and so is tobacco. It leads to cancer, and lung disease, and heart disease. And we know that it takes nearly 400,000 precious American lives each year. And we know that it costs us billions annually in lost productivity and health care costs.

We are fighting an all out war to keep our kids off drugs. We've targeted resources for drug education. We've appointed a Federal drug czar and we are trying to get more money into our cities and States to fight drug abuse. But what have we done to keep our kids away from tobacco? What have we done to prevent our children from taking an often fatal first puff and becoming addicted for life? Not enough.

We see 11, 12, 13 year olds smoking cigarettes in our schools and shopping malls, but the Federal Government hasn't made a concerted effort to stop it. We see 9 year old kids buying cigarettes from vending machines in our stores, but we haven't acted to prevent it. We see children being given free cigarette samples, but we haven't insisted that it stop.

If we saw a 10-year-old child holding a gun to his head surely we would intervene to save that child's life. We should have the same reaction when it comes to our kids smoking cigarettes. We need to act aggressively and intervene to prevent young kids from getting hooked.

I've introduced legislation, the Adolescent Tobacco Prevention Act, that would create two new incentive grant programs to encourage States to enact and enforce laws to limit youth access to tobacco products. The bulk of that legislation has been incorporated into the Tobacco, Education and Control Act of 1990, which was reported out of the Senate Labor-HHS Committee last week.

The Adolescent Tobacco Prevent Act would create incentive grants for States that enact and enforce laws prohibiting the sale of tobacco products to a minor under the age of 18. States that already have laws on the books would be given an incentive to enforce those laws. States would be encouraged to prohibit the distribution of free cigarette samples. The bill would also create an incentive grant to get States to make elementary and secondary schools smoke-free.

Under the bill States would be encouraged to ban the sale of tobacco products in vending machines, except in areas, such as bars and nightclubs, where minors, are not permitted. The ability of young people to purchase cigarettes through vending machines is inextricably linked to enforcement of minimum age laws.

If we are going to expect merchants to respect minimum age laws, it does not make sense to provide minors with access to tobacco products from vending machines. Now merchants can point to an unrestricted vending machine sale of tobacco products as a reason for continuing to sell to minors and we need to eliminate this disincentive. The need to act quickly and decisively to discourage young people from taking up smoking could not be greater.

The Federal Government needs to fight back to prevent young people from taking a fatal first puff and becoming hooked for life. The Federal Government needs to make a concerted effort to get the truth out, especially to young people about the grave health consequences of smoking tobacco. And the truth is, Mr. Chairman, and you know it well, that smoking cigarettes, smoking tobacco, kills.

I thank you very much, Mr. Chairman, and colleagues.

[The prepared statement of Senator Lautenberg appears in the appendix.]

The CHAIRMAN. Senator, we appreciate your testimony. What you are talking about is encouraging States to find ways to restrict access to tobacco for children. Do you know of any particular State that has a program going that you would like to highlight?

Senator LAUTENBERG. You'll forgive me, Mr. Chairman, if I mention the State of New Jersey that my colleague, Senator Bradley, and I represent.

The CHAIRMAN. We would have to put a time limitation of that certainly. [Laughter.]

Senator LAUTENBERG. Utah and Kansas, are three that currently require schools to be smoke-free. Washington State has a law that is going to become effective in September. So States are beginning to pick it up and we want to encourage them through this incentive program.

The CHAIRMAN. Thank you.

They say in Washington you have to say something 44 times before someone says, "By the way, did you hear what he said?" You may have almost crossed that threshold.

Thank you very much, Senator.

Senator LAUTENBERG. Thank you very much, Mr. Chairman.

The CHAIRMAN. I beg your pardon. Your colleague from New Jersey.

Senator BRADLEY. I just want to thank Senator Lautenberg for his testimony and his leadership on this issue. I think of him every time I get on an airplane and I do not have to worry about passive contamination through smoke. I know that he is there on this issue every day.

Senator LAUTENBERG. Thank you very much. I know your interests, Senator Bradley; and I know that you have legislation pending as well that would affect this. I thank you both for the opportunity to appear before you.

The CHAIRMAN. Thank you, Senator.

We are very fortunate to have our distinguished Secretary, Secretary Sullivan, who has been in the forefront of this fight and has come up with some creative ideas. We are looking forward to hearing you, Mr. Secretary.

STATEMENT OF HON. LOUIS W. SULLIVAN, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary SULLIVAN. Thank you very much, Mr. Chairman. It's a pleasure to have this opportunity to appear before you to discuss a very important issue. I appreciate the attention that you are giving to the problem of tobacco and health.

Tobacco addiction inflicts a horrible toll on our nation's health, particularly on the people served by the programs under your jurisdiction. It is for this reason that it is urgent that we join hands to develop workable strategies to rid our people of this scourge.

This hearing today is especially timely because May 31 is World No-Tobacco Day. This event which is sponsored by the World Health Organization is much like the Great American Smoke-Out. The theme of World No Tobacco Day this year is Smoking and Children.

Today I will highlight the problem of tobacco addiction as it affects our nation's children and youth. I also want to discuss some of the steps my Department is taking to reduce the sale of tobacco to youngsters. It is a moral and medical outrage that our society permits so many of its children to have such ready access to a product that does so much harm.

Cigarette smoking remains the single most important preventable cause of death in our society. Smoking is directly responsible for about 390,000 deaths each year. Something like one in every six deaths in our country is associated with smoking. It is astonishing to realize that the number of Americans who die each year from diseases caused by smoking exceeds the number of Americans who died in all of World War II. And this toll, unfortunately, is repeated year after year after year.

I am particularly concerned about smoking among pregnant women, and among our children and teenagers. Women took up smoking in the large numbers in the 1940's and 1950's and it is clear that the tobacco companies today see women as a big market. We have heard advertising campaigns attempt to associate smoking with women's liberation. They proclaim "You've Come a Long Way, Baby."

But smoking is anything but liberating. It is addicting. These advertisements use appealing images to mask an awful reality. The reality is that smoking is a killer and an equal opportunity killer at that.

Let's look at some of the facts. Lung cancer has overtaken breast cancer as the number one cause of death from cancer among women and lung cancer death rates among women continue to increase at an unrelenting pace. Other smoking-related diseases, such as heart disease and emphysema also are exacting a terrible toll on women in this country.

For example, a recent article published in the New England Journal of Medicine showed that women who smoke are more than three times as likely to have a heart attack as women who have never smoked. Smoking is an area where women are unfortunately outdoing men in one respect; at present, young women are more likely to smoke than young men.

Women who are addicted to tobacco are obviously affecting their own health, and that is unfortunate enough. But women who smoke during pregnancy are undeniably affecting their own babies. Women who smoke during pregnancy are more likely to have miscarriages and they are more likely to have dangerously small babies, or babies who die during infancy.

To put it in very plain terms, being born too small is a hazard to your health. And too many of our babies are suffering this hazard as the result of women smoking during pregnancy. The danger of smoking during pregnancy is real—smoking doubles the risk that a baby will die—and it is pervasive—there are around 900,000 infants born each year to smoking mothers. Many of these infants are adversely affected.

We know that smoking increases a woman's chances of having an underweight baby. Anyone who has held an underweight baby in their arms, as I have, realizes what a tragedy it is to have a child begin its life way behind the starting line. It is all the more

tragic when smoking is the cause, because smoking is avoidable. As you are no doubt aware, Medicaid covers much of the cost of the hospital care that is required for low birth weight babies when they are born to very low income mothers. So it is certainly fair to say that smoking is pushing up the cost of that program.

We know that elimination of smoking among child-bearing women would greatly reduce infant mortality and many other health problems and their associated costs. Accordingly, my Department conducts a number of programs which are trying to develop educational methods that can be used to reduce smoking among pregnant women.

For example, through the Smoking Cessation in Pregnancy project the Centers for Disease Control is providing assistance to States to develop and integrate smoking cessation information into public prenatal services. If the development of these educational methods is successful then they can be applied more broadly.

Smoking among young people is a special concern of mine that I want to highlight today. Smoking among high school seniors actually declined between 1976 and 1980. But since 1980 it has leveled off. The really disheartening news is that some 1 million teens start smoking each year. This amounts to about 3,000 each day. And many of these go on to become addicted for life.

In fact, about 90 percent of adult smokers began their addiction as children or adolescents. So the conclusion is clear, these young smokers account for almost all of our future problems. We know that the younger a person is when he or she starts to smoke the more likely he is to become a long-term smoker and to develop smoking-related diseases.

Preventing youngsters from taking up smoking is far more cost effective than treating addiction later in life; and certainly far less expensive and more humane than treating the resulting diseases from smoking.

As long as a significant proportion of teens views smoking as desirable, adult pleasure, and become addicted before they can make a mature judgment, we will never succeed in eradicating smoking.

It is all too apparent that we as parents, as educators, as health officials, and as legislators, still do not take the problem of smoking among our children and adolescents as seriously as we should. We allow, for example, a constant barrage of cigarette advertising that portrays smoking as safe, sexy, sophisticated—themes which appeal strongly to impressionable adolescents. And we have found it convenient to look the other way as cigarettes are openly sold to our nation's youth.

As with so many other health issues, tobacco addiction should be attacked with prevention measures, and this means that we should mount a vigorous effort to discourage our children and youth from ever starting to smoke. With this in mind, I want to present to you today a new initiative, one which I believe has the potential to make a great contribution towards smoking reduction among youth.

Last March I asked the Inspector General in my Department to assess the enforcement of State laws prohibiting the sale of cigarettes to minors. I also asked my staff to find methods that the States could use to improve the enforcement of these laws.

So I am releasing the Inspector General's report today. I would like to summarize it and introduce a copy of the report for the record, Mr. Chairman.

The CHAIRMAN. That will be done.

[The report appears in the appendix.]

Secretary SULLIVAN. The findings in this report boil down to this simple and unacceptable fact—our children can easily buy cigarettes virtually any time they want in violation of the law. Clearly, something has to change.

Let me now provide to you the highlights of this report. First, 44 States and the District of Columbia have laws which make it an offense for retailers to sell cigarettes to minors. However, these laws are being blatantly ignored. Of the 44 States with such laws, only 5 could even tell our investigators how many violations had been identified either at the State or municipal level. These five States found a total of 32 violations in 1989 and the remaining States simply didn't know. Thus, nationally we can document only 32 violations of the State laws while we know that almost 1 billion packs of cigarettes are illegally sold to our youngsters each year; this is truly a national disgrace.

Thirdly, two-thirds of the State public health officials reported that there was virtually no enforcement of their State laws, and most of the rest said enforcement was minimal. Because most youth access laws are criminal statutes only the police can enforce them. And, of course, our police and our courts are already swamped and lack the resources to enforce these laws.

Over 80 percent of both students and adults interviewed by our Inspector General reported that it is easy for youth to buy cigarettes. Over 60 percent of the vendors agreed.

As you can see, the overall enforcement record is abysmal. The Inspector General, however, did find tiny pockets of active enforcement, mostly local communities with strong and enforceable laws.

The report identified 11 jurisdictions where officials have made serious attempts to end the sale of cigarettes to minors. These jurisdictions are successfully enforcing their laws and have offered recommendations for even better performance.

The effective enforcement tools include: (1) licensing of tobacco vendors and revocation of licenses for violations; (2) civil, rather than criminal, penalties for violators; and (3) bans or restrictions on vending machines. Above all, these communities have found that leadership by government officials, accompanied by local support and commitment, are vital.

In sum, where State and local officials work at it, these laws can be successfully enforced. We all agree that the job should be done; and I think that the job can be done, Mr. Chairman. In just these few communities it is likely that thousands of youth will avoid addiction and will have longer, healthier lives.

What other public health initiative can promise such results at such low cost?

I also asked my staff to use the experience of successful and not so successful enforcement efforts to develop a model law which States could adopt. And today I am releasing the "Model Sale of Tobacco Products to Minors Control Act." I recommend that every State in the union consider legislation along these lines. I hope

that the nation's Governors, all of whom are certainly interested in practical preventative health measures, will get behind legislation to attack this critical problem.

We will be working with the leadership of the National Governors Association and other groups to assure that the model bill is considered in each and every State. I would like to have the proposed legislation introduced in to the record at this point, Mr. Chairman.

The CHAIRMAN. That will be done, Mr. Secretary.

[The information appears in the appendix.]

Secretary SULLIVAN. Thank you.

The main features of the proposed model law are as follows: First, it would create a licensing system, similar to that used to control the sale of alcoholic beverages. Thus, a store could sell tobacco to adults only if it avoids selling to minors. Signs stating that sales to minors are illegal would be required at all points of sale. The bill would establish a graduated schedule of credible penalties for illegal sales so that store owners and employees face a punishment that is proportional to the violation. Those who comply would only pay an annual license fee.

The proposed law would rely primarily on civil penalties to avoid the time delays and the costs of the court system, but allow use of local courts to assess fines similar to traffic enforcement.

The bill would ban the use of vending machines to dispense cigarettes. This provision reflects the difficulty of preventing illegal sales from these machines. Now, in recognition of the economic impact of this provision on vending machine owners, States may wish to consider a phased approach, leading to their complete ban.

Now, I understand that these measures will draw the usual protestations of innocence and benign intention from the tobacco industry. But the fact is that the tobacco merchants profit handsomely from the seduction of our children into nicotine addiction. In fact, according to a study newly released in the Journal of the American Medical Association this week, the tobacco companies earn an estimated $1.26 billion annually from tobacco sales to children, amounting to 947 million packs of cigarettes, and 26 million containers of smokeless tobacco sold to our children.

We must put an end to the time when any child with a handful of change can commence the slow motion suicide that has taken the lives of millions of Americans. We must put an end to the sacrifice of our children on the tobacco merchants' altar of profits.

Mr. Chairman, this proposal represents only one of the initiatives that we are taking. You are well aware of my abiding concern for the impact smoking is having on women and minorities.

I look forward to working with you and other members of Congress to promote a tobacco free lifestyle. Unlike many of the issues which this committee wrestles with each year, moreover, smoking reduction can be achieved at very low cost to Federal or State budgets. Elimination of this addictive substance will do more to enhance the quality and the length of life in the United States than any other step that we could take.

I would be happy to answer questions, Mr. Chairman, that you or other members of the committee might have. Thank you.

[The prepared statement of Secretary Sullivan appears in the appendix.]

The CHAIRMAN. Thank you very much, Mr. Secretary, for an excellent presentation.

I recall a study some years back that said that for people who smoked cigarettes then quit the relapse rate was almost identical to heroin addicts. It is just incredible the way they get hooked. And thinking of that certainly makes me believe that you have to get to these young people at a very early age to keep them off cigarettes and convince them it should not be done. That is why I think your model law for the States is a good step forward and I will do everything I can to assist in trying to talk to Governors and urging the adoption of it.

The other one, your testimony on the effect of smoking during pregnancy for women, and what it does to low weight birth babies, and the problems that often come with that—sometimes physical, sometimes mental. It is difficult for me to understand why young females seem to be taking up cigarettes more than young men. Do you understand it? Can you tell me what is causing that?

Secretary SULLIVAN. Frankly, Mr. Chairman, I do not understand it. I believe that among the factors is the fact that many of our young women during child bearing years really do not know or understand the adverse affects of smoking on their pregnancy. So that is why I have been so outspoken to really try and educate the public about this. It is inconceivable to me that a mother would knowingly impair her pregnancy and impair the health of her baby that she will have, and impair the likelihood of that baby surviving.

So I believe that we need to do everything that we can not only to educate our young citizens, but also to make tobacco less available to minors. This action will really send a message to our young people that we really are serious about this. I think as long as tobacco is easily accessible to our minors then certainly in the adventuresome spirit that is part of youth, the message they receive is that this really is not important or is not hazardous. But I think that by what we propose in our model legislation we will help to send that message, as well as to continue our educational efforts.

The CHAIRMAN. Thank you, Mr. Secretary.

I yield to my colleague from New Jersey who has helped lead the way in try to find ways to deter or decrease smoking in this country. He has worked at it diligently and effectively. Senator Bradley?

Senator BRADLEY. Thank you very much, Mr. Chairman.

Mr. Secretary, let me compliment you on your testimony and also on your—one might even say—courageous leadership on this issue. You have a lot of things that come across your desk and you have to make your choices about what is important to the health of the American people. I think it is not only noteworthy, but praiseworthy, that you have chosen to take as a central issue for you the need to reduce the consumption of tobacco and cigarette smoking in this country.

I assume you do that because you are concerned about the health of the American people, and particularly young people. I applaud

you for your suggestion today with the Model Sale of Tobacco Products to Minors Control Act.

It seems to me that many of your efforts have been directed at the problem that you actually restated today—that is, a lack of knowledge on the part of the public that even after all of the studies and all of the work that people still do not understand that smoking kills; and that the 400,000 people who die every year in smoking-related diseases, that message is not getting through.

The fact that 34 percent of the high school seniors do not believe that smoking a pack a day was dangerous to their health or that nearly a third of the women of child bearing age do not know that smoking causes still births, or the 30 percent of the smokers who do not know that smoking causes heart disease. I mean those statistics on the one hand are absolutely shocking. Your efforts, I think, are directed at the point of let's get the facts to the public. Let's get the facts about the dangerous health effects of smoking to the public.

Is that not what you are interested in?

Secretary SULLIVAN. That is correct, Senator Bradley.

Senator BRADLEY. Let me ask you, what has been the most startling thing to you as you have thought about this issue?

Secretary SULLIVAN. Well, among the factors that I think are increasingly impressive is the whole array of studies that are coming forward to show clearly that tobacco is a substance that really kills our people. As you know, there was a recent study that has now been reported showing that some 30,000 or 32,000 individuals die every year from heart disease caused by passive smoking.

Now we have known for a number of years about the effects of passive smoking in causing lung cancer where the number of people projected to die each year from cancer due to passive smoking is around 3,000 or 3,500. Here we have 10 times as many who have now been shown to die from heart disease due to passive smoking. That is another fact that I emphasize because we constantly here the issue of smokers' rights.

Well, I am interested in the rights of all of our citizens. When your rights' or my rights or others rights to the ability to breath free air, not contaminated by toxins and poisons—when that right is compromised by someone else in the room or next to me on an airplane—that really is taking a right away from me.

Therefore, I certainly was very pleased and want to commend you and the other members of the Congress for the legislation that was recently implemented concerning smoking on airplanes.

Senator BRADLEY. Now if I could, your efforts are directed at getting messages to the consuming public about the dangers of smoking. On the other side of that equation there is the tobacco industry which bombards people with messages that they should smoke and that use advertising methods to convince children to smoke. You pointed out yourself advertising targeted at certain segments of the population in a kind of insidious way to lure them into the habit so that you have a lifetime consumer.

I mean, don't you think that it would be wise to attempt to, if we could, put the full cost of that advertising out there for the public to in some way—is there any reason why American taxpayers should subsidize tobacco advertising at $1 billion a year?

Secretary SULLIVAN. I think that's certainly a very good question, Senator Bradley, because of the fact that we do have a substance that causes tremendous death and disability in our population. As you know, I am charged by the President to come forward with the plan concerning changes in our health care system. One of those charges is to contain costs.

I maintain that for us to get there from where we are now, we have to have a significant measure of prevention and changes in the health behavior of our population. When you look at health promotion and disease prevention, the number one cause of preventable death and disability in our society is use of tobacco.

So clearly, we cannot have it both ways. We cannot continue to abuse our bodies with cigarettes, alcohol, and other substances, or by not using seat belts, and expect to be able to have a health care system that will come in and patch us up and still contain costs. So clearly, I think that the advertising of cigarettes, which really links cigarettes with being attractive, successful, wealthy, and having all of the good life, is a false message. That is a misleading message. Smoking has absolutely nothing to do with that. In fact, smoking has the opposite effect.

I maintain that our tobacco companies, by that kind of juxtaposition—and also by trying to link their name with sporting events, trading on the image of good health that professional athletes convey—I say that that practice is not only irresponsible, it is misleading. Smoking has nothing to do with being an NBA player or being a member of the Football Hall of Fame. I venture to say there is not a single person in that Hall of Fame who is a smoker. It is just the opposite.

So clearly, I think that that kind of message, that is not only portraying a product to the public that is harmful, but also doing it in a false and misleading way, indeed, should not be supported.

The CHAIRMAN. Thank you very much, Senator.

I would like to call on the newest member of this committee, we are looking forward to serving with him, Senator Breaux of Louisiana.

OPENING STATEMENT OF HON. JOHN BREAUX, A U.S. SENATOR FROM LOUISIANA

Senator BREAUX. Thank you very much, Mr. Chairman. Thank you for welcoming me to the committee as well. I am delighted to be able to serve and hope to do the committee justice.

Thank you, Mr. Secretary. This is the second time we have met this morning. We were with a different committee earlier on and I appreciate being with you again.

Let me follow up on something that you said. You mentioned in your testimony something about we cannot have it both ways. But I am concerned at what I am hearing from the administration is an attempt to in fact have it both ways. Because in the past we have had Special Trade Representative, now Secretary of Agriculture, fight for trade sanctions against countries that do not allow U.S. tobacco products to be exported into their country. We have a Department of Agriculture which aggressively supports and defends a price support program for tobacco programs. We have trade repre-

sentatives who have fought for the right to advertise tobacco products in other countries which were prohibiting our advertising of those products.

And yet now you again on behalf of the Administration is trying to make a very eloquent case, and you do so, about the inherent evils in the program that other Departments of our own government are in fact trying to fight to promote. It seems to me listening that we are trying to have it both ways on behalf of the administration. Can you tell me why that is not true?

Secretary SULLIVAN. Yes, Senator Breaux. I would say that that is not a correct characterization because of this fact. Clearly, I think that the questions you raise are very legitimate and appropriate ones about, for example, our trade policy. This is an issue about which our trade representative and I have had discussions. I have been assured by Ms. Hills that our program or our policy concerning our trade with other nations is this, so far as tobacco is concerned: Those nations who wish to mount an anti-tobacco effort, we will support them. We will work with them. We will offer them not only technical assistance, but the experience that we have had here.

The issue that our trade representative has put forward to other nations is one of equity. The fact is, tobacco is a legal product even though it causes all of the problems that I have alluded to. But, we open our borders to importation of cars and stereos and computer chips and other products from other nations because we have a market here and we allow those nations that produce those products to have access to our markets.

The nations where we have had those trade discussions are nations that already have their own tobacco market; and, in fact, one of those nations that is protesting very highly this issue actually imports cigarettes that they produce to other countries in Southeast Asia.

Senator BREAUX. The point I am making—I appreciate your discussion on it. But it seems like you are advocating restrictions on advertising of tobacco products over here and yet other Departments of our own government are fighting to open up the ability to advertise those very same products in foreign countries. I mean that is really a fact. I mean they are actively, aggressively seeking to open up markets for U.S. tobacco products—for the right to sell them, the right to advertise them in foreign countries, with the aggressive support of our own Departments over here.

And yet your Department is doing the exact opposite in this country. To me, it seems like we ought to get a consistent policy, whatever it is going to be. There are others that are doing exactly opposite in the Cabinet than you are saying you are trying to do up here.

Secretary SULLIVAN. Let me correct that impression, Senator Breaux. One nation in particular, the nation of Thailand, is one nation that has been in the news a lot recently. I am told that initially in our trade representative's discussions with Thailand, the question of advertising was one of the concerns. That has long since been dropped. That is, our trade representative is not insisting on advertising in that country of American products.

My position is not to restrict advertising. I think advertising should be accurate and should be fair. I maintain that the images that are used by the tobacco companies in their advertising campaigns are misleading. I think you have—I think you have right here before you in this poster—a very good example of that.

So the tobacco companies also look at the public notification about that, versus the affect of tobacco. The rest of that picture is in brilliant, beautiful color. The Surgeon General's notice is in black and white in a small box down at the bottom in small type. I cannot read that from here, but I can read all the other things.

That is misleading advertising because the important health message in that poster is really very hard to see it. That's what I mean about misleading, inappropriate advertising.

The CHAIRMAN. If I could interrupt just a minute, Senator. We have a vote. I would like to let Senator Daschle make a comment and then we would be able to release Dr. Sullivan; and then we have two votes back to back, so we would have to stand in recess until 11:30. And, Dr. Sullivan, then you could get on to your other responsibilities.

OPENING STATEMENT OF HON. THOMAS A. DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator DASCHLE. Mr. Chairman, thank you very much. I want to associate myself with the remarks of our newest member, especially some of the comments and questions that he has made in regard to "having it both ways."

I had another thought in mind in coming to the committee this morning. It is to talk about something that deeply concerns my people in South Dakota. We are very proud of the rich diversity we have in our State. We have the largest Indian population per capita of any State in the country, and we are currently celebrating a year of reconciliation in South Dakota. We have had a lot of differences, some significant problems among our people over the last hundred years, and at long last we are trying to reconcile those differences.

We are proud of the fact that we have an association with Indian culture and the contribution that that culture has made to the State of South Dakota. Part of that contribution comes from the great Sioux language. In fact, we derive our State's name from the Sioux language. Dakota means friend. We are proud of that name.

That is why we are outraged at the thought that anybody could throw that proud name on a package of cigarettes. This year of reconciliation has done one thing that we have not been able to do in a hundred years—united Indians and non-Indians alike. All 700,000 people are marching in unison for the first time in history. It is in that unanimous fashion, Mr. Secretary, that Indians and non-Indians alike are furious at this marketing scam that is going on right now. We want it stopped.

South Dakotans should not be the only ones who want this kind of outrageous promotional act stopped. If it is Dakota today, is it Texas tomorrow? Is it Hawaii tomorrow? Is it California? Where does it stop? Maybe we will have an Indian brand some day.

Mr. Secretary, you have shown us some real leadership when you helped to stop the marketing of Uptown cigarettes and I just hope you will do the same thing with Dakota cigarettes. It is outrageous. It is the most flagrant violation of the name that we have seen in 100 years. It has to be stopped one way or another and we are going to do it.

Secretary SULLIVAN. Thank you, Mr. Daschle. I certainly support your outrage. I share your outrage there. Because that particular cigarette, in addition to appropriating the good name of the States of North and South Dakota, also is a cigarette that was being, I think, disgracefully marketed toward poorly educated young, white women.

The reason for that is that is the one population group in our society where smoking is increasing. Now somehow the tobacco companies cannot figure out that what they are doing is inducing our young people to smoke, but they have reams of data to know where precisely to target their product with this Dakota brand.

So I think that when you speak of having it both ways, the tobacco companies have had it both ways for many years. I think that this committee, and the Congress, and certainly we in the administration should, indeed, put a stop to that.

The CHAIRMAN. Thank you, Mr. Secretary. I have pushed us to our limits on the time we have to make that vote. So we will now stand in recess until 11:30.

Thank you, Mr. Secretary. We appreciate having you.

Secretary SULLIVAN. Thank you.

[Whereupon, the hearing recessed at 11:10 a.m. and resumed at 11:32 a.m.]

The CHAIRMAN. If you will please cease conversation and take your seats. This hearing has been reconvened.

Our first panel will be Jonathan Klein, a pediatrician at the University of North Carolina, testifying on behalf of the American Academy of Pediatrics; Hon. Charles Whitley, senior consultant for the Tobacco Institute, Washington, DC; Dr. John Oates, professor of medicine and chairman of the department of medicine at Vanderbilt University, testifying on behalf of Coalition on Smoking OR Health.

STATEMENT OF JONATHAN D. KLEIN, M.D., PEDIATRICIAN, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, CHAPEL HILL, NC

Dr. KLEIN. Good morning, Mr. Chairman. Thank you. My name is Jonathan Klein. I am an instructor in Pediatrics at the University of North Carolina at Chapel Hill. I would ask your permission to submit some additional background material for the record as well.

[The material referred to above and Dr. Klein's prepared statement appear in the appendix.]

Dr. KLEIN. It is a privilege to appear before you today on behalf of the American Academy of Pediatrics, whose 39,000 members are committed to the promotion of infant, child and adolescent health. My colleagues around the country and I are deeply concerned about the serious health hazards to children that result from tobacco smoking. Children who live in homes with smokers are involun-

tarily exposed to smoke. This passive smoking results in a variety of health hazards, including more lung infections, more chronic respiratory diseases and more lung cancer.

The Academy strongly supports legislative initiatives to eliminate or reduce the exposure of children to tobacco smoke and to encourage children not to smoke. The hazards of smoking for children begin even before birth. The 30 percent of women who smoke during pregnancy have increased risk of spontaneous abortion, low birth weight and fetal death, and their children are more likely to die during the neonatal period too.

Elimination of smoking during pregnancy must be part of national and regional efforts to reduce the incidents of infant mortality and low birth weight. Because of their dependence on adults, children and infants have inescapable risks of passive smoke inhalation. Children exposed to tobacco smoke have an increased frequency of lower respiratory track infection. Numerous studies have found that bronchitis, ear infections, pneumonia and potentially fatal respiratory syncitial virus lung infections occur more often in the children of parents who smoke than in children of parents who do not smoke.

Furthermore, the frequency of these infections increases with the amount of exposure. Children who live with two adults who smoke have more infections than those who live with only one. The problems associated with these exposures result in more disability days for these children; it also results in more frequent and longer hospitalizations and higher overall death rates.

Another hazard that the children of smokers face is that of death or disability due to fires. It has been estimated that cigarettes are the cause of 30 to 40 percent of all house fires, resulting in several thousand preventable deaths each year.

Passive smoking also has long-term health effects on children. Children whose parents smoke have decreased lung function and less lung growth compared with children of nonsmokers. They have an increased frequency of chronic respiratory symptoms, especially persistent wheezing. And recent evidence from the National Health Interview Survey found that maternal smoking is associated with higher rates of asthma and more severe asthma, too.

Studies from the NIH have also shown a significant relationship between lifetime exposure to passive smoke and lung cancer risk. This risk is greatest for those people whose exposure to passive smoke began during childhood. In addition, as Secretary Sullivan mentioned, new evidence reported this week conclusively shows that involuntary exposure to cigarette smoke also results in a predisposition to developing heart disease.

The Surgeon General has estimated that 6 million teenagers smoke and another 100,000 children less than 13 years of age also smoke. Young people whose parents smoke are almost twice as likely to smoke cigarettes as those whose parents do not. Many cigarette advertising campaigns incorporate youthful symbols in children's role models, and there is mounting scientific evidence that cigarette advertising and promotion does, in fact, influence young people to smoke.

Smokeless tobacco—snuff and chewing tobacco—is also increasing among children and adolescents. Smokeless tobacco is a proven

human carcinogen and has a high potential for addiction to nicotine. Widespread and carefully targeted campaigns promote the mistaken notion that smokeless tobacco is safe. It is advertised frequently and has been distributed free of charge to youngsters at sporting events and rock concerns. Prominent athletes, musicians and other teen role models are often involved in its promotion.

A 1981 report concluded by the FTC concluded that cigarette advertising may be deceptive because its themes and imagery have a capacity or even a tendency to deceive. For example, many cigarette ads attempt to allay public anxieties about the hazards of smoking. Some advertisements associate smoking with good health, athlete vigor, social or professional success and other attractive ideas.

The cigarette is portrayed as an integral part of youth, happiness, attractiveness, personal success and an active, vigorous lifestyle. As recently reported by the Centers for Disease Control, the ban on radio and TV advertising has resulted in a shift to other promotional devices, including sporting events, free samples, discount coupons and prominent displays in motion picture productions. And much of the advertising of cigarette companies is directed towards adolescence. Higher excise taxes on cigarettes have been shown to be an effective deterrent in the purchase of tobacco products.

And most importantly though, research from the University of Michigan has shown us that children and youth are more sensitive to price than are adults. Adolescents smoke less when the price of a pack of cigarettes goes up. Increasing tobacco excise tax or forcing manufacturers to bear the full cost would result in fewer children smoking.

The Academy believes that health hazards of involuntary smoking are of sufficient importance that they require national leadership now. The Academy believes we must do everything possible to eliminate the exposure of children to tobacco. Since 1986 we have formally supported a ban on all forms of advertising, in all media, for all tobacco products. But short of that we would support legislative efforts to relieve taxpayers from underwriting the costs of advertising tobacco products.

Campaigns specifically designed to influence young people and the sale of tobacco products to young people must stop. The Academy encourages Congress to require counter advertisements, and we also support increasing the excise tax.

Thank you very much. I would be happy to answer any questions.

The CHAIRMAN. Surely.

We will proceed with the rest of the panel. Mr. Whitley, who is the Senior Consultant for the Tobacco Industry. Mr. Whitley?

STATEMENT OF CHARLES O. WHITLEY, SENIOR CONSULTANT, THE TOBACCO INSTITUTE, WASHINGTON, DC, ACCOMPANIED BY LARRY C. HOLCOMB, PH.D., ENVIRONMENTAL TOXICOLOGIST

Mr. WHITLEY. Thank you very much, Mr. Chairman, for this opportunity to appear before you and to speak on behalf of the tobac-

co industry on many of the issues that have been covered this morning.

The committee's press release indicated that the hearing would cover monetary and social cost and alternative approaches to help discourage young people from starting to smoke. One of the things I will cover, and I hope the Chairman can indulge me with a brief time, is the tobacco industry's initiatives to discourage youth from smoking. And I would also like to comment at some length on some of the specifics of Dr. Sullivan's proposal and other aspects of his testimony.

Let me say, Mr. Chairman, that prior to the hearing this morning we had not seen a copy of, and still have not seen a copy of, Dr. Sullivan's specific Model Law that he says he will propose to the States.

The CHAIRMAN. Let me say, Mr. Whitley, you will have to comply with the time limitations as everyone else. But, we will let you submit additional information and once you have seen the Model Law as proposed by the Secretary to add further evidence to the record from your standpoint.

Mr. WHITLEY. Thank you, Mr. Chairman. Let me say briefly that his model appears to be copied very closely from restrictions on the sale of alcoholic beverages. The Federal Government didn't just use moral suasion as apparently he plans to do with the States to urge adoption of his code, but as the Chairman knows Congress used the threat of withholding Federal funds to require the States collectively and individually to adopt 21 as a minimum age at which you can buy alcohol. All alcohol is sold by dealers under a licensing set-up of the type he is apparently proposing.

So you would think that if his proposal actually had great potential to reduce smoking among youth that you would have had great reduction in drinking by youth. But the Chairman knows, as we know, that the most recent surveys of high school students have produced good news and bad news. The good news is that the use of illegal drugs—marijuana, cocaine and the like—is down. But the most recent surveys indicate that—alcohol has become the drug of choice—and the use of alcohol by teenagers is up.

So the very type of thing that he proposes there has not worked in relation to alcohol. Now the Secretary has a good idea in the general area of increased education. We have been involved in that, Mr. Chairman, in the past, our industry has. We expect to continue to be involved in it in the future. We have distributed over 700,000 copies of publications in connection with a cooperative effort with the State Association of School Boards, made them available to parents, teachers, others who deal with young people, giving ideas on how to counsel young people in this area of making the right lifestyle choices and particularly making the choice not to smoke.

We have been accused of targeting our advertisement to youth. That is not true, Mr. Chairman. We have adhered to our Code. We do not advertise in any publications that are directed primarily to young people under 21 years of age. The two publications that were mentioned this morning—People Magazine, Sports Illustrated—the overwhelming majority of the readership of those publications are adults and not children.

Mr. Chairman, it has been said that existing laws are not being enforced. The Chairman knows that laws that have popular public support are enforced. Those that do not have popular public support are rarely enforced. The Chairman knows that the Federal Government has forced the States to adopt speed limits. And in areas like maybe the western part of your State where you have long, wide stretches of highway, the laws are not popularly supported and they are simply not enforced.

Now in areas where there has been popular support for enforcement of the laws against selling cigarettes to minors, for example, in Utah—the report that the Secretary referred to, has shown that in the State of Utah there were over 4300 citations issued against teenage purchases of cigarettes, or against dealers who sold to teenagers.

So clearly, Mr. Chairman, the extent to which local laws are being enforced depends on the support at the public level for it. And again the idea of additional education of parents and young people as to the hazards of smoking would be very helpful. Certainly our industry does not encourage and in fact discourages young people from smoking in a variety of ways. We are currently reviewing all of our policies in that regard. We would anticipate in the near future we are going to expand our own education effort.

The testimony you have heard said that young people are sensitive to price. If you put on high taxes, they won't buy cigarettes. Well the truth is, in New England, which has the highest average total cost of cigarettes anywhere in the country, the consumption is one of the highest in the country among teenagers.

Senator Bradley's bill was mentioned earlier. And the notion that somehow something you don't tax you are subsidizing. We do not understand why our industry in that regard is different from all others. We believe that Senator Bradley's bill which would not permit us to write off the cost of doing business as every other industry writes off the cost of doing business would be contrary to the Constitution.

Mr. Chairman, we are submitting a legal brief from the firm of Covington & Burling in that connection. I would like to ask that it be made part of the record.

The CHAIRMAN. That will be done.

[The information appears in the record.]

Mr. WHITLEY. Also that Dr. Holcomb, who is accompanying me, that his statement be made a part of the record.

The CHAIRMAN. That will be done.

Mr. WHITLEY. We have a statement by Jolly Ann Davidson in connection with our efforts in youth education; and I would also like to ask that that be accepted for the record.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Whitley, that will be done. I think you are going to need all you can get. [Laughter.]

[The prepared statements of Dr. Holcomb, Jolly Ann Davidson, and Mr. Whitley appear in the appendix.]

The CHAIRMAN. Dr. Oates, we are delighted to have you. He is a professor of medicine and chairman of the department of medicine, Vanderbilt University.

Dr. Oates?

STATEMENT OF JOHN OATES, M.D., PROFESSOR OF MEDICINE AND CHAIRMAN, DEPARTMENT OF MEDICINE, VANDERBILT UNIVERSITY, NASHVILLE, TN

Dr. OATES. Thank you, Mr. Chairman.

The principal fact about cigarettes is simple and it is shocking. An estimated 390,000 Americans will needlessly die this year from the nation's most preventable cause of death, which is cigarette smoking.

Today I represent the American Cancer Society, the American Heart Association, and the American Lung Association, acting jointly as the Coalition on Smoking OR Health. These three organizations, which comprise the coalition, commend the committee on Finance for convening this hearing regarding the health impact and the financial impact of smoking.

Each of our organizations has devoted great portions of our resources in our efforts to discourage cigarette smoking. In Washington the three associations have worked together pursuing legislative initiatives and the furtherance of their health promotion and disease prevention mission.

Let me immediately address the two primary issues which are the focus of this hearing. The first is the health impact of smoking. As a physician I have personally witnessed the suffering and the death that the tobacco industry has inflicted on my patients. I have seen many lives needlessly lost. I have observed the horrors that tobacco can work on the human body, as well as the pain that is borne by the survivors of victims of cigarettes.

It is impossible to fully describe to you the magnitude of these human tragedies. I will share with you the evidence. Each day more than 1,000 people will die from tobacco use. That is the equivalent of nearly three loaded jumbo jets crashing with no survivors every day. Most of these victims of tobacco will die from one of three diseases—cancer, cardiovascular disease or chronic obstructive lung disease.

There is now an epidemic of lung cancer. And it is growing. Cigarette smoking is responsible for 83 percent of all lung cancers and 30 percent of all cancer deaths. Thousands of passive smokers—that is, people who do not smoke but inhale the smoke of smokers who surround them—will also die of cancer. Lung cancer has surpassed breast cancer as the number one cancer killer among women.

Cardiovascular disease is the number one cause of death in the United States, and cigarette smoking is one of the major independent risk factors for heart attack. And further, it augments the risk produced by other risk factors. The smoker's risk of heart attack is more than twice that of nonsmokers and their risk of sudden death is even greater. And this risk rises as the amount of smoking increases.

Approximately 80 to 90 percent of all chronic obstructive lung disease deaths are attributable to cigarette smoking as is the misery of shortness of breath that these individuals suffer before they die.

In terms of the financial impact of smoking, no dollar value can be placed on the lives that are lost yearly as a result of cigarette

smoking. Yet we do know that our country spends billions of dollars annually in treating tobacco-related illnesses and that the economy loses billions more as a result of lost productivity from ill smokers.

Secretary Sullivan has mentioned this data but it is worth emphasizing. The United States spends an estimated $52 billion annually in treating smoking-related illnesses. Compared with the current 16 cent excise tax, the health care costs of smoking equate to about $1.80 per pack of cigarettes, and that does not even include the other economic costs of smoking.

Of course health care costs are borne by the Federal Government. An analysis by the Office of Technology Assessment in 1985 estimated that the Federal Government spent somewhere between $2.1 and $6.6 billion, with a middle estimate of $4.2 billion, in treating smoking-related illnesses through Medicare and Medicaid programs. Adjust these figures to 1990 dollars and the smoking-related health care costs borne by the Federal Government is undoubtedly much higher.

While each of us is being forced to bear the enormous costs associated with smoking, the tobacco industry is spending more than $3 billion annually advertising and promoting its products. This advertising is subsidized by the Federal Government. The industry maintains its advertisements are solely intended to encourage those who already smoke to switch brands.

I would like to draw your attention to one ad which is contained in our submitted testimony. This ad done in cartoon format instructs hesitant coupon redeemers, translate teenagers, to call upon a friend or a kind looking stranger to redeem a free pack of cigarettes for them. Can anyone believe that this is aimed at anyone but underage youth?

Unfortunately, in an environment in which children have free access to tobacco products the industry's efforts are having success. Fully 90 percent of all tobacco users will initiate their habits while teenagers or younger. Those children who begin to smoke will smoke their first cigarette at an early age. One in 10 of 8th grade smokers will have smoked their first cigarette at grade 4 of below.

Mr. Chairman, it is these young children about whom I am concerned. Those who become addicted to cigarettes in their childhood lose their freedom of choice. As adults they remain addicted to tobacco and often fall victim to premature death. This committee has the ability to save millions of lives. We know children are the most price sensitive consumers of tobacco products. By increasing the Federal cigarette excise tax you will discourage hundreds of thousands of young people from starting to smoke.

According to one recent economic analysis, a 16 cent increase in the Federal excise tax would diminish the teenage smoking population by 17 percent, a reduction of 820,000 teenagers who smoke.

Mr. Chairman, the Coalition commends the Committee on Finance for exploring the health and financial impact of smoking. Now is the time to act. We can no longer stand by as our nation's children become addicted to the one product legally sold in our country that when used as intended kills. We urge the Senate Committee on Finance to endorse an increase in the Federal cigarette

excise tax as well as the elimination of the tax deduction that subsidizes this kind of tobacco advertising.

Thank you.

[The prepared statement of Dr. Oates appears in the appendix.]

The CHAIRMAN. I must say that is powerful testimony, Dr. Oates.

Mr. Whitley, the subject of the hearing this morning is the consequences of tobacco smoking on health. And yet as I scan through your testimony you do not seem to touch on that one at all. Do you dispute the data which links smoking to cancer, emphysema, to heart problems?

Mr. WHITLEY. Mr. Chairman, we certainly acknowledge the existence of a long series of epidemiological studies that show statistical associations between cigarette smoking and certain diseases. It is on the basis of these statistical associations that the surgeon general and others have concluded that cigarette smoking causes these diseases.

I would point out, Mr. Chairman, that for many years Congress has looked at this issue and Congress has determined that based on the findings of the Surgeon General and others that cigarette packages and cigarette advertising should carry specific health warnings, which they do.

I would point out that in 1985 the Department of HHS did its own survey. That survey showed that 98 percent of the American people had heard that there was a health risk associated with smoking, that 95 percent of them believed that smoking was related to lung cancer, that 93 percent of them believed that it was related to heart disease, that 91 percent of them believed that it was related to emphysema.

Now the American public apparently has chosen, those who smoke, are making an informed choice. They have been told that there is a health risk associated with smoking. They, of course, know that there are health risks and other risks associated with many other lifestyle choices that they make.

The CHAIRMAN. Thank you.

Dr. Klein, we hear a lot these days about environmental smoke, the effect it has on spouses who don't smoke and children. Are the effects of passive smoking, are they more injurious to children and if so, why? Could you give me some rudimentary information on why infants or children might be especially vulnerable?

Now I don't want an education on biology, but if you could——

Dr. KLEIN. I will try and keep it short, Mr. Chairman. Basically, children have smaller lung passageways than adults do. These airways are how we get our air from the environment and through our respiratory passages into our lungs. Children's airways are smaller because children are smaller. The irritating effects that smoking has on lung tissue has the same effect on children's lungs that it does on adult lungs, except that there is less leeway. There is less room for that irritation to be compensated for.

It is especially a problem for children who were also low birth weight. As the Secretary pointed out, low birth weight is more common among women who smoke during pregnancy and so these children not only start out behind, but they are less able to fight off the irritation and the constant assault that smoking has on their lungs.

Another point which I would like to make is that in fact the publications that carry the bulk of tobacco advertising in this country are specifically targeted to youth. In contrast to what the gentleman to my left said, Sports Illustrated has one of the highest rates of tobacco advertising and it is specifically aimed at adolescent boys. Twenty-five percent of them read the publication, and in fact, even 10 percent of adolescent girls read Sports Illustrated.

The CHAIRMAN. Thank you.

I'm going to have to leave early because I am part of the negotiating group on the summit on the budget. Senator Bradley will be chairing, but I turn to him now for his questions.

Senator BRADLEY. Thank you very much, Mr. Chairman. I assume you want me to proceed.

Well, let's see, there is a lot to cover here. Let me ask the panel: Do you believe that advertising of tobacco products increases the use of those tobacco products?

Mr. WHITLEY. May I begin on that, Senator?

Senator BRADLEY. By the way, before you begin you quoted some studies about 95 percent of the American people know. What is that study?

Mr. WHITLEY. That study was conducted by the Department of Health and Human Services in 1985. We would be glad to get a copy and submit it for the record if you would like.

Senator BRADLEY. Good. That's fine.

[The study appears in the appendix.]

Senator BRADLEY. All the numbers you used came from there?

Mr. WHITLEY. Yes.

Senator BRADLEY. Okay. Good.

Do you want to answer the question?

Mr. WHITLEY. The question of whether you can expand the market for cigarettes by advertising. There is absolutely no empirical evidence anywhere that indicates that this can be done. In fact, the Surgeon General's own report, as it relates to young people has said specifically that there is no rigorous scientific study anywhere that indicates that advertising causes young people to smoke or to begin to smoke.

Michael Pertsohnk, who is a well-known anti-smoking advocate said several years ago, there is no longer anybody who seriously believes that advertising causes young people to smoke. All of the empirical studies that we know anything about, Mr. Bradley, have indicated that the major cause and almost the sole cause of young people beginning to smoke is peer influence, the influence of family members, siblings, parents, and the like. They do not start to smoke because they have seen smoking advertisements and the same is true of adults.

Senator BRADLEY. All right.

Mr. WHITLEY. In the advertising world generally certainly the makers of laundry detergents do not expect to increase the market for their product because they advertise it. They would like to sell their brand. Our advertising is the same.

Senator BRADLEY. So why do you spend $3.3 billion on smoking advertising and promotion?

Mr. WHITLEY. Mr. Chairman, our members companies and the——

Senator BRADLEY. I mean you obviously want to increase your sales, don't you?

Mr. WHITLEY. Well the company that advertises wants to increase the sale of its brand, just as Mr. Iacocca wants to increase to the car market that's there the sale of Chrysler products. Our companies want to increase the sale of their brand and to maintain brand loyalty among the customers they already have.

Senator BRADLEY. Studies show only 10 percent of smokers switch. So you spend $3.3 billion for 10 percent of the smokers?

Mr. WHITLEY. Mr. Chairman, 1 percent market share in the cigarette industry in this country is worth about $558 million.

Senator BRADLEY. Say that again.

Mr. WHITLEY. $558 million.

Senator BRADLEY. One percent of market share is $558 million on the sale of cigarettes?

Mr. WHITLEY. That is right.

Senator BRADLEY. How many cigarettes is that?

Mr. WHITLEY. I cannot extrapolate that to the number of cigarettes.

Senator BRADLEY. That is a lot of cigarettes though, right?

Mr. WHITLEY. Yes, it is. Yes, a lot of cigarettes are sold and smoked. There are between 50-55 million Americans who are smoking cigarettes.

Senator BRADLEY. Does anybody else want to deal with the advertising question? Dr. Oates?

Dr. OATES. Yes. I think that perhaps overlooked in the advertising issue is the fact that this is one way that the industry attempts to control the press in the United States. There have been a number of surveys that have shown through very careful examination that the amount of cigarette advertising in the press is very closely correlated with the amount of information that is carried in specific magazines, particularly that tries to inform their readership about the health risk of smoking.

Senator BRADLEY. You mean in a magazine where there might be a negative tobacco article that there might be an advertisement essentially saying, no, you get power and wealth if you smoke, that kind of thing?

Dr. OATES. Well there is that, but there is also documentation indicating that the magazines that carry a high prevalence of cigarette advertising do not address the health issues of smoking to the same extent of those magazines that do not carry cigarette advertising. If you look at those women's magazines that carry a lot of cigarette advertising, they will address other health issues of women, such as contraception and so forth extensively, but stay virtually completely away from the health risk of cigarettes and women and the fact that cigarettes augment the cardiovascular death rate from contraceptives.

I think that they have been very successful in exploiting the women's movement with their advertising. Virginia Slims and now Dakota, which has captured them, an increasingly number of young women who begin to smoke.

Senator BRADLEY. Dr. Klein?

Dr. KLEIN. I would agree with what he said and also point out that cigarette advertising is a way of sending a message to teen-

agers or children that cigarette smoking is socially acceptable. Advertising in the social environment also increases the volume of cigarettes smoked by individual smokers. It can make it harder for smokers to quit—because they are seeing a smoking message; and it can make it more likely that smokers who have quit might relapse. Again, this constant social message.

We know from health education studies that increased repetition of messages is effective and the same is true for advertising.

Senator BRADLEY. Let me ask you, you have some of this. But here is an advertisement. It says, "From one smooth character to another." Personal. That grabs your attention, right? You open it up. "Suitable for framing. Open carefully." You open it up. "Free pack offer. Free poster." And a chance to order eight more. Keep on going. You open it up and there it is. The thing that you see before you. What is this supposed to tell the person who gets this in the mail?

Dr. Oates? Dr. Klein? Mr. Whitley? What is this supposed to tell? Here is this very attractive woman leaning against a sports car. Why is that in the picture?

Mr. WHITLEY. Well, Mr. Chairman, I do not profess a great deal of personal expertise as to why advertising agencies make up ads exactly the way they do. Clearly what you have there is an offer. If you read on down you will see that the offer is limited to smokers over 21 years of age.

Senator BRADLEY. A free pack of Camel.

Mr. WHITLEY. To smokers over 21 years of age.

Senator BRADLEY. But what is this saying?

Mr. WHITLEY. I don't——

Senator BRADLEY. Who gets down to this fine print?

Mr. WHITLEY. Well if you order the cigarettes you get down to the fine print.

Senator BRADLEY. Yes.

Mr. WHITLEY. Because before you can order any cigarettes you have to sign a coupon and on the coupon it says that you're a smoker——

Senator BRADLEY. Right.

Mr. WHITLEY [continuing]. That you're over 25 years of age and you have to send that back to the company.

Senator BRADLEY. Twenty-five?

Mr. WHITLEY. Twenty-one years of age.

Senator BRADLEY. Over 21.

Mr. WHITLEY. Over 21 years of age and you have to return it to the company through the mail before you ever get any free cigarettes.

Senator BRADLEY. Dr. Klein, what is this saying? What are they trying to say?

Dr. KLEIN. Mr. Chairman, when I see adolescents in clinic I sometimes show them tobacco ads so that we can talk about what they mean. What they tell me about ads like that is, well they're trying to get you to think that if you're a smooth character you'll smoke Camels. Then we talk about the fact that that's not really true.

Senator BRADLEY. If you are a smooth character? What?

Dr. KLEIN. I talk about the fact with them that it is not really true. But we need you to act at a national level to make it impossible for those kids to get those messages in the first place.

Senator BRADLEY. Dr. Oates, what does that ad say to you and your people?

Dr. OATES. Well that ad speaks of sexual attractiveness, the good life. It attempts to associate these features with cigarette smoking. And its use of the comic strip format clearly is targeted at people who are younger than Mr. Whitley and myself.

Mr. WHITLEY. I read the comics everyday.

Dr. OATES. I note an additional kind of advertising that must be important to the tobacco industry because they put it in full page format in our newspaper, utilizing such esteemed American figures as Abraham Lincoln and Franklin Roosevelt and Lech Walensa, all under the rhetoric of freedom of choice.

I wish, Senator, to champion true freedom of choice about smoking. The choice should be an informed and a mature choice, which cannot be made by children who are most of the people who are taking up smoking today. Because most smokers begin during or even before their teenage years, they enter adulthood already addicted and deprived of the freedom to make an informed and a mature choice.

We cannot speak about freedom while enslaving our children.

Senator BRADLEY. I would like to yield to Senator Symms because I did not see him over there behind the TV camera. I apologize to you, Senator, for not recognizing you.

Senator SYMMS. Thank you, Mr. Chairman. That is okay.

OPENING STATEMENT OF HON. STEVE SYMMS, A U.S. SENATOR FROM IDAHO

Mr. Chairman, I want to welcome the panel here and apologize to the next panel also, that I have another engagement that I have to leave for. But I do want to ask a couple of questions and I would hope that each of the panelists could just very briefly answer the question. I would also like this question to be worked into the testimony of the next panel of witnesses as well.

The one question that bothers me is, number one: Do smokers actually pay their own way? Are we nonsmokers subsidizing those people that smoke because of health care, taxes, et cetera, or are the smokers already paying enough to pay their way for their decision to smoke? That's the first question.

The other question I am concerned about is: Do smokers actually miss more work than others? Not talking about the time that it takes to smoke on the job, which I think is obvious that if people are smoking it is distracting from their other work, but I'm talking about do they actually have more days off work.

I would hope that each of you could address that. My apologies if I leave here. I am a little bit behind schedule. Very briefly, please. Just start down the line.

Mr. WHITLEY. Thank you.

Senator SYMMS. Dr. Klein or my former colleague, from the House Ag Committee—it's nice to see you here, Charlie.

Mr. WHITLEY. Thank you, Senator.

Let me respond to those two questions briefly if I may. Number one, is there a so-called social cost to smoking? Is there a cost that is imposed by my smoking that someone else pays? That is the basic question.

There are all kinds of numbers that are thrown around as to what constitutes this so-called social cost. You arrive at it in two ways. First of all, as the argument is made, as you said, the smoker is less productive, that he misses more time on the job, that he abuses his sick leave, this sort of thing. There is absolutely no empirical evidence anywhere to show that that is the case. That is a value judgment. It is an anecdote. Some people think that is the truth, but there is no evidence to show that.

If it is true, if it should be true, that cost is not paid by society, it is paid by the smoker. If the smoker misses time at work he loses wages. If he abuses his sick leave he hurts his promotional opportunities. He hurts himself, primarily, if he does those things. So that's the answer to that part of the question.

Now what about medical expense. Well people in this country pay their medical expense in three basic ways. They make direct payments to the provider. Smokers do that just like everybody else does. If they belong to some kind of an insurance plan they pay their premiums. Smokers do that just like everybody else does. If they participate in some kind of government-financed health program they do pay or have paid taxes that helps support those programs. Smokers pay in everyone of those ways just like everybody else does.

And in addition, Senator, they pay a very high excise tax already at every level of government—State, Federal and local. The excise tax today, average nationwide, on a pack of cigarettes is between 38 and 39 cents a pack. That brings in billions of dollars at every level of government. So if there is a cost associated with smoking, there is no evidence that the smoker doesn't pay that cost just like the nonsmoker does.

The main users of health care in this country are the elderly, people with chronic diseases, and children, many millions of whom in every one of those groups are not smokers and have never been smokers. And there are millions and millions of healthy smokers in this country who are not disproportionate users of medical care. They too are paying not only their own way, but paying this excess already in the form of excise tax. So, no, there is not any cost that is being occasioned by smokers that is not paid by smokers.

Dr. OATES. Yes. I am glad you asked this question because I think it is central to our considerations today. The excise tax does not even come close at the present time to paying the cost that smoking inflicts on our society. The current tax accounts for only about 10 percent of the estimated health care cost of smoking. This does not even include the additional cost in terms of loss of productivity.

The loss of productivity is very clear. One only has to come and visit with a group of our patients who have chronic obstructive lung disease and see that they are often unable to walk across this room without experiencing severe shortness of breath. Most of these patients are under age 65 and should be employed. Instead

they are collecting benefits from our society, benefits that are paid to support the tobacco industry.

It has been said that cigarette smokers pay for health insurance, but in fact they drive up the premiums that the rest of us have to pay and it is these premiums that are one of the factors that are making our country economically uncompetitive in the international scene and that our health care costs make up such a large fraction of the exported products of the United States.

So that there is no fairness in the current excise tax that allows the smoker to get away with paying only a tiny fraction of the costs that he imposes on society.

Dr. KLEIN. The respiratory problems that children have more frequently as a result of their passive smoke exposure results both in more disability days for themselves and also for more out-of-work days for their parents. So there are costs related to the work effects there as well to increased costs for more hospitalizations and longer hospitalizations.

There are already over 3 million children in this country who have asthma. It is one of the leading chronic diseases. The costs of those cases that are due to or are made worse by tobacco smoking have never been factored into the overall cost to society or the cost to our future to our children.

I think that there is no question that you can manipulate numbers to show that smokers might pay their own way in some specific cases. But if you look at the total cost to society and the total public cost of the disease burden from tobacco, it is clear that smokers are not paying for it, nor are smokers the only one suffering. We need to address those issues.

Senator SYMMS. Thank you, Mr. Chairman.

Thank you, gentlemen.

Senator BRADLEY. Thank you very much, Senator.

Is smoking addictive, Dr. Klein?

Dr. KLEIN. Nicotine is one of the most addictive drugs that we know of, Senator.

Senator BRADLEY. Mr. Whitley?

Mr. WHITLEY. Mr. Chairman, the Surgeon General's report, which concludes that cigarette smoking is addictive, also makes the point that some 41 million Americans have quit smoking. Nearly half of those Americans who have ever smoked cigarettes have quit smoking cigarettes successfully. Over 90 percent of those without any outside help.

Senator BRADLEY. So do you think it is addictive?

Mr. WHITLEY. It certainly is not addictive in the way that hard drugs are addictive, Mr. Chairman.

Senator BRADLEY. Is it an addictive substance from your standpoint?

Mr. WHITLEY. I think that is the wrong term.

Senator BRADLEY. No, it is a question. It's a direct question.

Mr. WHITLEY. No. I do not agree that it is addictive.

Senator BRADLEY. You do not think it is.

Mr. WHITLEY. I think it is habit forming.

Senator BRADLEY. Okay.

Mr. WHITLEY. But I don't think it is addictive.

Senator BRADLEY. All right.

35-777 O - 91 - 2

Dr. Oates?

Dr. OATES. Senator, unquestionably smoking is addictive. The 1988 Surgeon General's report examined the data and came to the conclusion that the behavioral and pharmacologic processes that determine the addiction to cigarettes are very similar to those processes that determine addiction to heroin and to cocaine.

I think that most physicians, including myself, knew well before 1988 that smoking is addictive, as we have seen our patients who have smoking-induced illnesses struggling to try to stop and are unable to do so. We see patients who have severe chronic obstructive lung disease who have recently just come off of respirators pick up their cigarette. They cannot stay away from it knowing that they are not going to be able to breath because of the damage that this inflicts on their lungs.

Senator BRADLEY. Have you ever known anyone who stopped smoking? Are there any withdrawal symptoms?

Dr. OATES. There are some withdrawal symptoms associated with smoking. Perhaps the most important factors that determine the addiction, however, are the compulsive behavior, the fact that this is a powerful psychoactive substance that is characteristic of all of the addicting drugs.

The comment that half the people quit does not help us in the definition of addiction because even heroin addicts after some time are able to—half of them or more—come off of this drug. It is just a terrible——

Mr. WHITLEY. Without any special help?

Dr. OATES. Oh, yes.

Mr. WHITLEY. Without any medical assistance?

Dr. OATES. Yes. It is a terribly addicting problem for those who are not able to come off. So you cannot use the simple fact that some people are able to get off of any drug as evidence that it is not addictive. The process of withdrawal is painful.

Senator BRADLEY. Dr. Klein?

Dr. KLEIN. I would agree with Dr. Oates. And I would just point out that we know from numerous studies that the average number of times that a successful quitter has quit is seven times. I believe that one of the reasons it is so difficult for people to quit successfully is because they are bombarded by prosmoking advertising messages.

Senator BRADLEY. Mr. Whitley, you have maintained the minority position of the panel, that it is not addictive. I wonder then how you would explain the following document which is an internal document of a major cigarette company that came to light during the course of various litigations. I quote from the document.

"The cigarette should be conceived not as a product but as a package. The product is nicotine. The cigarette has been one of the many packaged layers. There is the carton which contains the pack which contains the cigarette which contains the smoke. The smoke is the final package. The smoker must strip off all of these package layers to get to that which he seeks. Think of cigarette pack as a storage container for a day's support of nicotine. Think of the puff of smoke as the vehicle of nicotine. Smoke is beyond question the most optimized vehicle of nicotine and the cigarette the most optimized dispenser of smoke."

Do you think it is addictive?

Mr. WHITLEY. Mr. Chairman, no I don't and that does not change my opinion.

Senator BRADLEY. I didn't expect that it would.

Mr. WHITLEY. Senator, that remark is taken completely out of context in an extensive speech that the gentleman made in which he talked about food being a nutrition delivery system. It was a very generalized discussion of many different things. There is nothing there, I think, that verifies that cigarettes are addictive.

Senator BRADLEY. Okay.

Mr. WHITLEY. You can say food is addictive. Many people are very unsuccessful in trying to reduce their eating and lose weight, more so than they are unable to quit smoking.

Senator BRADLEY. Now we are going to have a later panel, but I was just curious as to your rationale, Mr. Whitley, as to why a tax subsidy is a right. I mean you certainly have a right to free speech but you don't have a right to a tax subsidy. What is your thought on that?

Mr. WHITLEY. We have submitted a legal brief on that. Let me just say quickly, Mr. Chairman, that we sell a legal product like every other legitimate company in this country. We write off the cost of doing business just as other companies do. Our advertisement is a part of that cost, just as other companies advertisements is a part of their cost.

Clearly, if you and the Congress should decide that no advertising by anyone should be considered to be a part of the cost of doing business and you are not entitled to deduct it as a legitimate tax deduction, then you could do it with our product. But I don't think you can pick out a product that you do not like and say, okay, you cannot write off the cost of advertising that one. If we do like this one, you can write off the cost of advertising that.

The President of the American Bar said I would like your type of law if you let me pick out which products I like and which ones I do not like and let me say.

Senator BRADLEY. Let me ask you, I mean, are you aware of the Congress ever doing this in the Tax Code?

Mr. WHITLEY. I don't know of a situation where Congress has singled out one manufactured product and say you cannot write off the cost of advertising.

Senator BRADLEY. What about a country? You know, tax benefits accrue to people who invest, period. Your theory. But the Congress said no, if you boycott it, you don't get the tax benefit. Now could you tell me? I mean, do you think that should be repealed?

Mr. WHITLEY. I'm sorry——

Senator BRADLEY. What about tax credits that were denied to companies that invest in certain places?

Mr. WHITLEY. Tax credits?

Senator BRADLEY. That's right, tax credits, tax benefits, tax subsidies.

Mr. WHITLEY. Well that is not really a part of the cost of doing business.

But let me say this, Mr. Chairman——

Senator BRADLEY. But are you aware of those things?

Mr. WHITLEY. Yes.

Senator BRADLEY. You are?
Mr. WHITLEY. Yes.
Senator BRADLEY. Which countries are they applied to if you are aware of them?
Mr. WHITLEY. I cannot tell you the specific countries. Let me say this to you, Senator——
Senator BRADLEY. How many of them are there?
Mr. WHITLEY. I don't know.
Senator BRADLEY. Well then so you are not aware of them?
Mr. WHITLEY. I am generally aware. I am not specifically aware of all of those provisions.
Senator BRADLEY. Okay. But you do not have any problem with them?
Mr. WHITLEY. I don't know. I didn't really come prepared to address that issue.
Senator BRADLEY. Well, I mean, it is fundamental to your point. Do you have a problem with various countries being—if investment in various countries tax place being denied the tax subsidy?
Mr. WHITLEY. If we make investments in various countries that we are denied——
Senator BRADLEY. The tax subsidy.
Mr. WHITLEY. What kind of tax subsidy do you mean?
Senator BRADLEY. Various tax credits. The same thing, costs taxpayer dollars to do certain things, promote certain things. The question is whether those taxpayer dollars should be spent for investment in certain countries. You've said what?
Mr. WHITLEY. I said I am aware that that has been done. I am not aware that it has been contested and upheld in the courts.
Senator BRADLEY. Do you support that?
Mr. WHITLEY. I do not know. I am not prepared on that question.
Senator BRADLEY. Okay.
Mr. WHITLEY. I think it is a different matter entirely.
But let me say this, if I may, Senator, I think the tax reform that went through the Congress—and you were one of the moving forces behind that in 1986——
Senator BRADLEY. Right.
Mr. WHITLEY [continuing]. That one of the purposes in that reform, Senator, was to take out all these things that Congress tries to do to induce certain kinds of investments, to discourage others—to take the Tax Code and instead of making it into an instrument of policy where the Congress says what you should invest, what you shouldn't invest, do this, do that, try to make the Code more fair.
Senator BRADLEY. Right.
Mr. WHITLEY. Leave the money with the people who are earning it and making and let them make those decisions.
Senator BRADLEY. Right.
Mr. WHITLEY. This is a step back in the other direction.
Senator BRADLEY. Let me ask you: Do you think the things that the Secretary proposed today—education programs, generally about tobacco problems, about health effects—do you think that is a good idea to tell people about this possible detriment to their health?
Mr. WHITLEY. We ourselves have sponsored educational programs to encourage young people not to smoke.

Senator BRADLEY. Right.
Mr. WHITLEY. And to the extent he is talking about encouraging young people not to smoke, we support that motion.
Senator BRADLEY. And you would encourage the Federal Government to do that?
Mr. WHITLEY. Well I'm not sure exactly what the Federal role should be in terms of dollars and cents. Certainly the Secretary and others can use their——
Senator BRADLEY. You're in favor of it, but you don't want the Government to do it?
Mr. WHITLEY. Well I'm not sure to the extent—I would have to see each specific proposal.
Senator BRADLEY. I see. But generally you're in favor of it?
Mr. WHITLEY. Generally we have no quarrel with the notion of encouraging young people not to smoke cigarettes.
Senator BRADLEY. And generally you don't have any problem having money spent on that, your money?
Mr. WHITLEY. We are spending our money. We expect to spend additional money.
Senator BRADLEY. But you do not want the Government spending money?
Mr. WHITLEY. Well it depends on what the proposal is, Mr. Chairman. It is a blanket question.
Senator BRADLEY. Well it's the kind of question that if you support it—you support it for yourself. So that means you want to target the message, right?
Mr. WHITLEY. Well we would want to target it to young people and discourage young people from smoking.
Senator BRADLEY. Just like you advertise target messages, right?
Mr. WHITLEY. Well——
Senator BRADLEY. You do target messages to specific segments of the population, don't you?
Mr. WHITLEY. Every manufacturer in this country directs its advertising to those people who buy its product.
Senator BRADLEY. Right. So you do target? I mean would that be the way you'd do your education?
Mr. WHITLEY. That's your word. But certainly we direct advertising——
Senator BRADLEY. Well you don't target—do you target or do you not target?
Mr. WHITLEY. We direct our advertising to our existing market.
Senator BRADLEY. Right.
Mr. WHITLEY. We have an existing market of women for example.
Senator BRADLEY. Right.
Mr. WHITLEY. There are millions of American women who smoke. So we design advertisements and brands of cigarettes that are designed to try to sell to that market. An individual company wants to sell its product to the existing market of women.
Senator BRADLEY. Okay. Does anyone else on the panel want to comment?
Dr. OATES. As we have repeatedly mentioned, that the industry has provided an educational message to young people informing them about the risk of smoking. I would like to invite Mr. Whitley

to provide for the public record some examples of this so that we can see exactly what it is that is being provided to young people.

Mr. WHITLEY. We will be glad to do that. We have included a statement for the record by Jolly Ann Davidson who has been supervising that effort and we will be glad to submit specimens of the material that has been provided.

Senator BRADLEY. And could you submit also the total amount spent on the effort?

Mr. WHITLEY. I think so.

Dr. OATES. The industry is supposedly writing a brief on the constitutionality of the tax on advertising. I would simply say that in order to do this you are going to have to rewrite the Constitution. The First Amendment does not incorporate the privilege of subsidy in the right to free speech.

Senator BRADLEY. Dr. Klein?

Dr. KLEIN. I would just point out: Is it fair to market death and disease to the children of our country? Obviously it is not. Portraying the cigarette as an integral part of youth goes against everything that Mr. Whitley has said and is what they do. And the Academy of Pediatrics supports your legislative efforts to relieve taxpayers from underwriting these expenses.

Senator BRADLEY. One last question for this panel. I appreciate your time.

In California they recently increased the excise tax 25 cents which is about a 15 percent increase. And in 1989 consumption declined 14 percent. It was reported in the Wall Street Journal that if you increase the price of the cigarette that you would end up having much less consumption. The GAO estimated for example that with a 20-cent per pack increase in cigarette price, there would be 500,000 fewer teenagers smoking per year, and 125,000 fewer premature deaths. Now those are the lower end of the estimates. Some people say it is higher.

Do you generally concur with that relationship between increased cost and more lives being saved?

Mr. WHITLEY. Let me just first address the raw numbers of cigarettes being bought. You mentioned the California experience. In California there was an initiative on the ballot that——

Senator BRADLEY. Do you agree with those numbers, though, Mr. Whitley?

Mr. WHITLEY. No. No, I don't. Let me quickly tell you why. In California there was an initiative on the ballot and shortly before the vote the sales of cigarettes ballooned. It was obvious that persons in anticipation of that excise tax being levied sort of laid in a supply.

Senator BRADLEY. Hoarded, right? You mean hoarded them?

Mr. WHITLEY. No, bought them locally in anticipation of the excise tax going up. So they squirreled in a supply so that immediately after the vote there is a short-term drop off. Also, Mr. Chairman, if you will look at those areas——

Senator BRADLEY. So from that standpoint increasing the tax does not decrease consumption. So why are you worried?

Mr. WHITLEY. It did not in that case.

Senator BRADLEY. So why are you worried? We could raise the tax 50 cents and you would still be selling as many cigarettes.

Mr. WHITLEY. Well, Mr. Chairman, it does decrease consumption over time and it does among adult smokers—now there is no evidence that it does it with children. And, in fact, as we pointed out earlier, in the Northeast, which has the highest average cost of cigarettes anywhere in the nation, the rate of smoking by teenagers is higher on the average than it is in the rest of the country.

Now teenagers, unlike adults, who are living on a lower income do not have to pay for their own subsistence. Teenagers will pay $60 for a pair of Reebok tennis shoes. They will pay $10 for a music tape. They will pay $20 for a ticket to a rock concert. So the notion that——

Senator BRADLEY. Let me just interrupt you there. Most kids do not do that, Mr. Whitley. A certain class of kids does that. But most kids do not do that.

Mr. WHITLEY. Well I think the point I am making, Mr. Chairman, is that they do not have to buy necessities. They do not have to buy necessities with the money that is available to them. And to suggest that if cigarettes are as addictive as our fellow panelists claim, that a teenager would let 15 cents a pack make the difference in whether he smokes or doesn't smoke not only is——

Senator BRADLEY. So what is your opinion? Does it decrease consumption or not?

Mr. WHITLEY. It decreases total consumption. But there is no evidence that——

Senator BRADLEY. Decrease. Decrease, not increase. Does it decrease consumption?

Mr. WHITLEY. It decreases total consumption.

Senator BRADLEY. But you said it doesn't decrease it among teenagers?

Mr. WHITLEY. That is the empirical experience.

Senator BRADLEY. Okay.

Dr. Klein?

Dr. KLEIN. I'll keep this brief, Senator. The studies are fairly clear across the country, increasing the excise tax affects younger smokers more than older smokers. They have fewer disposable resources.

I would like to just give you an example about why I think we clearly need some national action here. Because there is a study out of Massachusetts and the State Department of Public Health in Massachusetts where they looked at their smokers in Massachusetts. They surveyed people and found out how many cigarettes they smoked.

They went to their tax rolls and they tried to figure out where those cigarettes came from and they could only find about two-thirds of the cigarettes that people were smoking in Massachusetts, which makes you suspect that they're coming from other places where they are cheaper. People behave rationally around some kinds of markets; there are a fair number of studies that show with cigarettes they do.

Senator BRADLEY. Dr. Oates?

Dr. OATES. I think the California data are consistent with all other data where there have been major changes in the cost of cigarettes, primarily increases from taxes. For example the Canadian experience showed that tobacco sales overall fell 23 percent

after the increases that occurred over a period of several years in that country.

I think the data are very clear about the price elasticity of smoking of teenagers. The adult smoker is committed—is addicted. And the reduction in smoking for a given increase in price is less. The computed price elasticity for the adult committed smoker is something like 0.4, which means that for a 10 percent increase in price, there will only be a 4 percent drop off.

But it is just the opposite for the teenage smoker where an increase of 10 percent would result in a greater than 10 percent decrease in smoking by teenagers. An important reason for this is that the teenagers are in a period of passing from experimental smoking into the addiction process. Therefore, they are much more price sensitive, and also this is a much more important target for us to intercede on to prevent them from entering into a life time of smoking.

Senator BRADLEY. Mr. Whitley, just a final comment on the California experience. You deny that there was this reduction?

Mr. WHITLEY. No. I'm just explaining that the short-term reduction is probably artificial and exaggerated. Because smokers in anticipation of the passage of that initiative on the ballot bought up a supply ahead of time; and also, if you will look at those areas near the border, you will see that the sales on the California side of the border have dropped and with corresponding increases on the Arizona side.

So I am just saying that that short-term drop that you described can be explained by factors other than people giving up smoking.

Senator BRADLEY. So it would be like a couple of months and then it would be back to normal. Is that what you think?

Mr. WHITLEY. Well I don't know about a couple of months, but——

Senator BRADLEY. But is the reduction——

Mr. WHITLEY [continuing]. I think it will be fairly close to what it has been if you discount for traffic across the border.

Senator BRADLEY. I see. Well the fact is that the statistic is for a full year. It is not for a couple of months; it is for a full year. And therefore to assert that it dropped off because people hoarded and then returned to normal patterns is kind of contrary to this.

Mr. WHITLEY. I think you are looking at wholesale deliveries rather than retail sales, Mr. Chairman.

Senator BRADLEY. Is it your understanding, Mr. Whitley, that there is a net cost to the Federal Government for the tobacco program?

Mr. WHITLEY. There is no net cost over time with the present program, except for administrative expense. You have cash flow fluctuations depending on the rate at which loans are being made by the Commodity Corporation, the CCC as opposed to——

Senator BRADLEY. Do you know how much that administrative expense is?

Mr. WHITLEY. I have heard a figure of $20 million, Mr. Bradley.

Senator BRADLEY. Well it is $11 million.

Mr. WHITLEY. All right. All right.

Senator BRADLEY. What about the indemnities?

Mr. WHITLEY. What about what?

Senator BRADLEY. Tobacco insurance, indemnities, what are they?

Mr. WHITLEY. Unless it is crop insurance you are talking about, I don't know, Mr. Chairman.

Senator BRADLEY. It just says—you know, this is from the Secretary of Agriculture, I don't know too much about this. I thought you might.

Mr. WHITLEY. I'm not sure what it means by indemnity insurance unless it is Federal crop insurance which applies to most agriculture commodities.

Senator BRADLEY. That is $28 million.

He says direct outlays are $36 million.

Mr. WHITLEY. Those direct outlays are commodity credit loans that come back in when the tobacco that is taken in is security for the loan is sold. That is a cash flow item.

Senator BRADLEY. Yes. The loans made were $98 million and repayments were considerably higher than that.

Mr. WHITLEY. Right. Right.

Senator BRADLEY. Okay. Well, let me thank the panel very much for your testimony. I think it has been very helpful. We have ranged here a little bit beyond just the health effects but we have to in order to get the issue clearly on the table. Let me thank you very much.

Our next panel will consist of Lonnie Bristow, a member of the board of trustees, American Medical Association; Mr. Robert Tollison, Duncan Black Professor of Economics, Center for Study of Public Choice, George Mason University; Mr. Robert J. Myers, former Chief Actuary, Social Security Administration, chairman, Commission on Railroad Retirement Reform, Silver Spring.

Would you gentlemen please take a seat.

Let me welcome you all to the committee. I apologize to you for going on longer than we expected. We do want to try to get through this if we can. So please try to summarize your remarks. The normal procedure is to take 5 minutes to summarize your remarks and then we will have questions after that.

Let's begin with Mr. Bristow.

STATEMENT OF LONNIE R. BRISTOW, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, SAN PABLO, CA, ACCOMPANIED BY MICHAEL ZARSKI, DIVISION OF LEGISLATIVE ACTIVITIES

Mr. BRISTOW. Thank you, Mr. Chairman. My name is Lonnie Bristow, a practicing physician and I am a member of the AMA Board of Trustees. And with me today is Mr. Michael Zarski of the Association's Division of Legislative Activities.

The AMA really appreciates this opportunity to appear before the Senate Finance Committee on the issue of tobacco and youth. Anyone who watches the electronic or print media today would begin to conclude that health advocates are experiencing some success in the war against tobacco use.

However, even though smoking rates are declining among all major demographic age, race and sex groups, there is one ominous exception which you have earlier referred to—young females. More

girls are now smoking than boys. And equally ominous is the growing popularity of smokeless tobacco.

An estimated 1.7 million children between the ages of 12 and 17 today are using smokeless tobacco which is a direct vehicle for nicotine delivery as you so aptly pointed out. Some 3 percent of the tobacco industry's current profits are coming from children under the age of 18, which in the majority of States is clearly an illegal activity.

We support Secretary Sullivan's effort to introduce model legislation. The AMA has similarly engaged in that particular direction, seeking to ban vending machines and seeking to have licensure imposed upon tobacco vendors at the State level.

One of the more recent AMA responses to this health challenge has been to create the "Kids Against Tobacco" Coalition or KAT. The charter members of this Coalition are some 70 health care and youth related organizations who are dedicated to helping kids to choose to be tobacco free. This program was announced at the Adolescent Health Congress convened by the AMA in Washington just this past May 11; and already we have received numerous calls for further information on the KAT Coalition since that announcement.

The Coalition will build a grassroots educational program focusing on efforts to help empower children to protect children. The campaign will be integrating existing tobacco use prevention and cessation resources into a comprehensive, clear, consistent message; a message which will be delivered to kids by their own peers.

This is just the beginning of what we hope to find as an exciting campaign. Many innovative approaches are expected to be brought forward and be integrated in the coming months and years. We have included with our testimony a Kids Against Tobacco information kit which the AMA and the Coalition members will be distributing. That kit contains facts on tobacco, including smoking, passive smoking and smokeless tobacco.

I would like to emphasize again that the KAT Coalition is a new initiative and we anticipate that the scope of the Coalition's activities and the membership roster will expand. We do appreciate this opportunity to inform the members of this committee about our activity and would like to commend the committee for your concern about tobacco use among young people.

I would like to conclude by urging you to approve two measures which are within your jurisdiction. These would address the problem we are discussing here today. First, the Federal excise taxes on tobacco products should be increased. The evidence is very clear that young people in particular are very price sensitive to the cost of tobacco products. The GAO report released last year calculated that an increase in Federal excise tax of only 20 cents a pack would likely result in over 500,000 fewer smokers, which in turn would lead, according to one estimate, to approximately 125,000 fewer premature deaths due to tobacco.

Secondly, we urge you to eliminate the tax deductions tobacco companies are allowed for their advertising and promotion expenses. While the tobacco industry denies that its advertising is targeted to children and adolescents, there is ample evidence that such advertisements do in fact reach youth.

Such recurring themes in tobacco advertising as you see displayed before the committee today which emphasize independence and sexual attractiveness have particular appeal to children and adolescence. Therefore, we strongly support the elimination of the tax deduction as being an important step in the right direction.

We again commend the Chairman and the committee for holding this hearing and we would be pleased to answer any questions you may have at this time.

[The prepared statement of Dr. Bristow appears in the appendix.]

Senator BRADLEY. Thank you very much, Dr. Bristow.

Dr. Tollison?

STATEMENT OF ROBERT D. TOLLISON, PH.D., DUNCAN BLACK PROFESSOR OF ECONOMICS, AND DIRECTOR, CENTER FOR STUDY OF PUBLIC CHOICE, GEORGE MASON UNIVERSITY, FAIRFAX, VA

Dr. TOLLISON. Thank you very much, Senator Bradley. I appreciate the opportunity to testify today. I am appearing here at the request of the Tobacco Institute to talk specifically about the so-called social cost of smoking. In fact, my remarks will go almost entirely to the two questions that Senator Symms put to the previous panel.

Senator BRADLEY. So you're a doctor of economics?

Dr. TOLLISON. Correct.

Senator BRADLEY. Okay.

Dr. TOLLISON. My point is really not complicated. I think that the concept that smokers by the act of smoking are imposing costs on nonsmokers or on society is what economists would call an empty economic box. It looks like science. It sounds like science. But when one opens the box and looks at the calculations and the data, what one finds is not science at all. You find an analysis that any economist worth his salt could rout, I think, fairly quickly. It basically turns to dust in your hands.

The argument is not that there are no costs to smoking, but that these costs are private costs borne and paid for by smokers and not social costs in the sense that that term has been used in professional economics.

The concept is simple. I can illustrate it by talking a little bit about this literature on the so-call social cost of smoking, which we have heard a great deal about already today. One of the largest items in these so-called accountings are productivity costs of smoking. The typical way this analysis is erected is, while not controlling for other factors, groups of smokers and nonsmokers are compared and it is claimed that smokers miss work more often than nonsmokers.

I know of only one careful econometric study of that issue which is forthcoming in an English economics journal called "Applied Economics" in which the researchers bother to gather a large body of data on work attendance rates and control for other relevant factors affecting absenteeism such as age. When you do that you find what I think common sense would suggest, that smoking does not have a statistically significant impact on work attendance.

So first of all the factual premise of these billions of dollar costs that are put in social cost studies is not correct, at least given the state of contemporaneous econometric research on the issue.

But secondly, what if it were? What if it were true that smokers due to illness or whatever missed work more often than nonsmokers? Who is going to pay for that? Where will competitive labor markets place the price of that behavior? It will clearly place it on the worker who is absent more often. It will not place it on other workers. In fact, other workers should be ceded a competitive advantage in the labor market if they are in fact competing against less reliable, less stable workers who are in fact alleged to be smokers.

So that is one example, I think, of a very large item in these studies. Some $30 to $40 billion is always larded into the productivity cost of smoking that ought to just be taken off the table. It does not belong there. It is a cost that is borne and paid for by smokers and not by society; and it offers no predicate for a public policy rationale to tax smokers.

You can go through a quite similar analysis with large parts of the health care cost that are put in these social cost studies of smoking. For example, private insurance payments by smokers and their employers are counted as costs that somebody other than the smoker pays. That just cannot be true. It is not true by definition. These are private, voluntary insurance arrangements entered into by smokers with an insurance company. In what sense does that impose a cost on anyone other than the smoker?

I could go on, Mr. Chairman, but you asked us to be brief. I think my summary statement simply is that this is an empty economic box. It is not a rationale for a tax on tobacco or for a regulatory scheme with respect to the behavior of smokers.

Thank you very much.

[The prepared statement of Dr. Tollison appears in the appendix.]

Senator BRADLEY. Thank you, Dr. Tollison.

Mr. Myers, welcome to the committee, as always.

STATEMENT OF ROBERT J. MYERS, FORMER CHIEF ACTUARY, SOCIAL SECURITY ADMINISTRATION AND CHAIRMAN, COMMISSION ON RAILROAD RETIREMENT REFORM, SILVER SPRING, MD

Mr. MYERS. Thank you, Mr. Chairman. It is always a pleasure and a privilege to be before the Senate Finance Committee, as I have done over some 40 years now. The appearance of the room has stayed the same over 40 years; I think my appearance probably has changed a little.

Senator BRADLEY. And probably the people up here have changed a few times.

Mr. MYERS. Yes, I think so.

Today, Mr. Chairman, I am going to deal with a study that I made as to mortality between smokers and nonsmokers and then give certain conclusions from that study with regard to the cost of the Social Security and Medicare programs.

Recently, I made an actuarial analysis of a survey that was performed in Erie County, PA as between lifetime smokers and lifetime nonsmokers. I think that Erie County is a fairly typical place in the country, so the results have a certain validity. This study was unique, among all studies that have been made of mortality of smokers, in that it was performed in the same way that the national life tables are prepared at the time of each decennial census.

We looked at the deaths among smokers and nonsmokers. We looked at the population as divided up between smokers and nonsmokers. The results were indeed surprising to me, as to the magnitude of the differences in life expectancy. In brief, the expectation of life that we found at age 30 for nonsmokers was 52.7 years, as against an expectation of life for smokers of only 34.8 years. A difference of almost 18 years.

Similar differentials applied for other attained ages. For example, at age 65, nonsmokers were found to have a life expectancy of 18.3 years, or somewhat more than double the 8.3 years for smokers.

There could, of course, be other factors involved that I think are immeasurable. People who do not smoke, perhaps might have more favorable physiological characteristics, but I am convinced that, despite this, the very significant differences that we found are indicative of the very high mortality associated with lifetime smoking.

Now taking up the point that Senator Symms raised, whether smokers pay their way or not, I do not think this can be accurately figured. There are too many counterbalancing elements. Many academicians attempt to make studies of this matter; and I do not think that they really can do so with any precision. For example, there have been a couple of studies in the last few years by people who pointed out that the Social Security program was going to have great financing problems if people quit smoking because then they would live longer. That does not seem relevant to me.

After all, there is the humane side of the matter, which is much more important than the social costs or the national costs. Do we want to solve Social Security's problems by getting people to smoke more and dying earlier? Of course not. Not anymore than we want to follow the Eskimo theory, or the supposed Eskimo theory, of solving the retirement problems by putting the aged persons outside of the igloo.

In Medicare, undoubtedly I think that smoking has cost the program net as compared to what would happen if people did not smoke. There are some cases, of course, where this does not occur. If a smoker dies before reaching age 65, as against that person living beyond age 65, obviously there is less Medicare cost. But I think that, in balance, the Medicare program has much higher costs because of smoking.

When we come to the Social Security program, obviously if people live longer, there are going to be higher retirement costs. But that is not a reason to encourage people to smoke. The answer to this matter, of course, is not that the Social Security program is not financially viable, but rather, if people were to stop smoking, were to be healthier, and were to live longer, they also would work longer. Then, we could do as we did in 1983—we could equitably

have a higher normal-retirement age than is now scheduled under present law.

I think that, in balance, any analyses that are made as to what are the costs of smoking, have to be taken with some skepticism, because there are too many elements to factor in. But we do know, and I think that we can conclude, that smoking is harmful to longevity and is therefore harmful to people, and that it would be a much better thing if people did not smoke. In such event, the Social Security and Medicare programs could adjust themselves quite well to the situation.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Myers appears in the appendix.]

Senator BRADLEY. Let me thank you very much, Mr. Myers for your testimony, and Dr. Tollison, and Dr. Bristow.

Let me if I can, Dr. Tollison, just whether you feel that, you know, an individual's right to chose means that Government should financially support basically the promulgation, the peddling of messages that encourage self-destructive behavior.

Dr. TOLLISON. The reference you are speaking to is the advertising exclusion?

Senator BRADLEY. Yes.

Dr. TOLLISON. I think so long as tobacco is a legal product to be bought and sold in the American market place that there is no particular reason to single out them for that exclusionary action when you would not exclude other industries from deducting their advertising expenses.

Senator BRADLEY. So it doesn't trouble you at all that, you know, if you could be shown that advertising leads to illness, leads to use of tobacco, leads to illness, leads to premature death—I'm try to get out of the economist box here.

Dr. TOLLISON. I understand.

Senator BRADLEY. Whether it is empty or not.

Dr. TOLLISON. I understand.

Senator BRADLEY. Just how do you feel about that.

Dr. TOLLISON. Let me just say that there have been a lot of words spoken this morning and this afternoon about the impact of advertising on the consumption of tobacco products. Mr. Whitley tried to say what I think is what the econometric literature on the impact of advertising on the sales of tobacco products actually concludes, which is that it does not have an impact on the aggregate demand for tobacco. It impacts the market shares of individual companies.

That means it is not growing or causing the market for smoking to grow and it is very easy to see why a firm would spend to maintain market share, because if they do not spend, they lose market share. And as Mr. Whitley pointed out market share is valuable to these companies.

So I see the issue of why young people smoke going to things like their friends, their peer group, their family habits, what one might call the family environment, and the kind of environment they are confronted with at home and not to the price of tobacco and certainly not to the advertising.

I think the evidence indicates fairly clearly that two things do not matter here. One is price; and the other is advertising.

Senator BRADLEY. Right. So I mean it doesn't matter how high the price is, people are going to still consume.

Dr. TOLLISON. I didn't say that. I said over the range of price increases that we have observed, including your reporting of the California example, I think a careful assessment of what is happening in California this year, next year, the year after will show that there was not an elasticity on the order of magnitude of a 15 percent drop in smoking due to that test. That would be two or three standard deviations away from all the reported elasticity estimates that we have.

Senator BRADLEY. So basically your point is, if you grew up in a family of Lucky smokers you are going to smoke Lucky unless this advertisement can pull you over to some other brand?

Dr. TOLLISON. Well if you grew up in a family of smokers, the probability that you are going to smoke is higher than if your parents didn't smoke.

Senator BRADLEY. Yes, but for this to be followed through, the probability that you would smoke a particular brand.

Dr. TOLLISON. That may be. I don't really know whether there's any kind of following behavior with respect to the type of product that's used.

Senator BRADLEY. Dr. Bristow, you know, 90 percent of the smokers actually begin before their 21st birthday. The AMA has some thoughts about nicotine as a drug and your efforts to include tobacco in the curriculum of drug-free schools back in your help of our effort, back in 1986. Do you think that the danger from tobacco warrants warning children that it may be addictive?

Dr. BRISTOW. Yes, I do, Senator. I believe that the decision to smoke is formulated in the early years, as you have pointed out. It is unusual to find someone who is 25 years old and decides to smoke. Everyday when I examine patients in my office I take a smoking history on new patients, and I do inquire how much they smoke, and I do inquire when they began smoking.

I would say 80 percent of the time is a reasonable estimate of the number of times I hear people saying they began smoking at age 13, 14, 15, 16. That is when people begin smoking. So that if we are going to try to affect the health outcomes that occur from smiling, that is where we have to start.

We are dealing with an industry that uses every subtle approach it can to reach young people. You will notice that poster that is sitting in front of the committee today. The Surgeon General's warning has been removed from the bottom of that poster.

The warning has been removed in order to get to the coupon that they can send in to receive free cigarettes. Then the poster goes on the wall. Now I don't think that was designed by the tobacco company accidentally. I think it was done very carefully and very deliberately.

So we are dealing with an industry that has its own moral codes and I think it is perfectly appropriate to set public policy which reacts to that. I think that answers the question that was raised before by the tobacco industry witness left who raised the issue about whether or not you should treat one industry different from another.

I think it's perfectly appropriate to set public policy in the best interests of the public and to respond to abuses by the tobacco industry.

Senator BRADLEY. Mr. Myers, do you have any kind of final comment on the economics that we were discussing here today? You have such a wide range in intellect, you can just choose which of the areas you would like to comment on as your parting shot.

Mr. MYERS. Mr. Chairman, I would conclude by summarizing that, regardless of the ethical or moral aspects of smoking, the result of smoking is clearly a very, very significant deleterious affect on longevity and on morbidity. And certainly regardless of the costs involved in Social Security or Medicare, the country would be much better off if people live longer and be healthier, and therefore more productive. The national product would be greater, and I think that all the evidence is that smoking very seriously affects mortality.

Senator BRADLEY. So would you support the denial of the deduction for advertising as a way to try to help reduce these costs?

Mr. MYERS. Yes, I think that I would do that. I would also support a much higher excise tax on cigarettes than a mere, whatever it is, 14 or 17 cents. I think that it ought to be $1 or $1.50 or $2. Maybe, this high tax for a while would help balance the budget until people quit smoking.

Senator BRADLEY. Mr. Myers, on your final comments, the committee will be adjourned.

Thank you all three.

[Whereupon, the hearing was concluded at 1:03 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF LONNIE R. BRISTOW

Mr. Chairman and Members of the Senate Finance Committee: My name is Lonnie R. Bristow, M.D. and I am a member of the AMA Board of Trustees. With me is Michael Zarski of the Association's Division of Legislative Activities.

The AMA appreciates this opportunity to appear before the Senate Finance Committee on the issue of tobacco and youth.

Anyone watching the news or reading the newspapers would conclude that health advocates are winning the war against tobacco use. Among other developments, smoking is now banned from most domestic airline flights; targeted populations such as minorities and women are objecting to tobacco advertising aimed at them; and state and local jurisdictions, even in tobacco-producing areas, are acting to protect non-smokers from the harmful effects of involuntary smoking by restricting smoking in public places.

Smoking rates are declining among all major age, race and sex groups with one ominous exception: young females. More girls are now smoking than boys. Equally ominous is the growing popularity of smokeless tobacco, particularly moist snuff among male adolescents. The average age of first use of smokeless tobacco is 10.8 years old. An estimated 1.7 million children between ages 12 and 17 use smokeless tobacco.

Our grave concern about tobacco use among young people stems from several factors:

1. Most smokers start as children. To a child, the long-term ad verse health consequences of tobacco use, like lung cancer and heart disease, seem impossibly remote. Children also underestimate the addictive nature of tobacco products.
2. Teenage smoking is associated with other forms of substance abuse. Cigarettes have been identified as a "gateway" drug—a psychoactive substance whose use is common among people who later use other drugs. Whether the use of cigarettes leads to substance abuse is not established, but cigarette smoking teaches kids important things about drug use which are helpful in learning how to acquire and use other drugs.
3. A number of adverse health effects result from kids smoking. Cancer and heart disease may be far down the road, but a more immediate health consequence of kids smoking is addiction to nicotine. In addition, any smoker, regardless of age, may contribute to the toll of heart disease and cancer among non-smokers due to second-hand smoke. Finally, the prevalence of teenage pregnancy and smoking places our children's children at risk of fetal and infant morbidity and mortality.

One of the American Medical Association's responses to this health challenge has been to create the "Kids Against Tobacco" coalition (KAT). The charter members of this coalition are 70 healthcare and youth-related organizations, dedicated to helping kids to choose to be tobacco-free.

The formation of the KAT Coalition was announced at the AMA Adolescent Health Congress on May 11, 1990 here in Washington, D.C. It was received with much enthusiasm from the educators and health care providers in attendance at the Adolescent Health Congress. The AMA has received numerous calls for further information on the KAT Coalition since the announcement.

The KAT Coalition will build a grass-roots educational program focusing on efforts to help empower children to protect children. The campaign will integrate existing tobacco use prevention and cessation resources into a comprehensive, clear,

consistent message—a message to be delivered by peers. It will also be provided both in and out of school on age-appropriate levels to provide reinforcement of the tobacco free choice.

To help reinforce the message, preteens and teens will be seeing the "PERFORMANCE EDGE" Public Service Announcement while they watch their music videos, and in other places as well. The "PERFORMANCE EDGE" PSA is the subject of a cooperative effort between KAT and the HHS Office on Smoking and Health. It ties in with video and magazine materials for teens prepared by the Office on Smoking and Health and the Office for Substance Abuse Prevention.

This is just the beginning of this exciting campaign, and many innovative approaches are expected to be brought forward and be integrated in the coming months and years.

We have included with our testimony a "Kids Against Tobacco" information kit which the AMA and coalition members will be distributing. The KAT information kit contains facts on tobacco, including smoking, passive smoking and smokeless tobacco.

Additional materials suggest "what you can do" as a parent, educator, legislator or young person.

Let me emphasize again that the KAT Coalition is a new initiative and we anticipate that the scope of the coalition's activities and the membership roster will expand.

We appreciate this opportunity to inform the members of this committee about our activity and we commend you, Mr. Chairman, for your concern about tobacco use among young people.

Let me conclude by urging you to approve two measures within your jurisdiction which would address the problem we are discussing here today. First, the Federal excise taxes on tobacco products should be increased. The evidence is very clear that young people in particular are very price-sensitive to the cost of tobacco products. An increase in the excise tax would discourage teen smoking which, over time, will substantially reduce the adult smoking population. The General Accounting Office released a report last year which calculated that an increase in the Federal excise tax of 20 cents a pack would likely result in over 500,000 fewer smokers. This would lead, according to one estimate, to about 125,000 fewer premature deaths due to tobacco.

Second, we urge you to eliminate the tax deductions tobacco companies are allowed for their advertising and promotion expenses. While the tobacco industry denies that its advertising is targeted to children and adolescents, there is good evidence that such advertisements do in fact reach youth. Some recurring themes in tobacco advertising, such as independence and sexual attractiveness, have particular appeal to children and adolescents. Cigarette advertising is very heavy in several magazines with large readerships among adolescents, such as Glamour (about one-quarter of readers are girls under age 18), Sports Illustrated (about one-third of readers are boys under age 18), and TV Guide (reaches approximately 8.8 million readers age 12 to 17).

The AMA advocates the total elimination of tobacco advertising and promotion and, after thorough legal analysis, we are convinced of the constitutional validity of an advertising ban. Due to controversy over this point, we support the elimination of the tax deduction as a step in the right direction.

Once again, the AMA commends you, Mr. Chairman, for holding this hearing and we would be happy to provide you and any other member of the Committee with additional information regarding tobacco, its health consequences and young people. And, of course, we would be pleased to answer any questions you may have at this time.

APPENDIX I.—POSITIVE RESPONSES TO THE KAT COALITION INVITATION

[As of May 16, 1990]

The following organizations have indicated that they would like their names to be announced at the AMA Adolescent Health Congress, and that they will provide a distribution network for the KAT Coalition information.

Aches 'n' Pains 4-H Club
American Academy of Pediatrics
American Association for Respiratory Care (AARC)
American Association of Retired Persons (AARP)
American College of Cardiology
American College of Obstetricians and Gynecologists
American College of Physicians

American College of Preventive Medicine
American Dental Association
American Hospital Association
American Lung Association
American Medical Association
American Medical Association Auxiliary
American Nurses' Association, Inc
American Psychiatric Association
American Public Health Association
American School Health Association
American Society of Internal Medicine
Arkansas Department of Health
Association of American Medical Colleges
Association of State and Territorial Health Officials (ASTHO)
Asthma & Allergy Foundation of America (AAFA)
Boy Scouts of America
Coaltion for a Tobacco-Free Utah
Colorado Stop Teen Addiction to Tobacco (C-STAT)
Office of Public Health Education, Delaware Division of Public Health
Doctors Ought to Care (DOC)
Georgia Department of Human Resources, Division of Public Health, Section of Community Health
Girl Scouts of the USA (GSUSA)
Group Against Smokers' Pollution (GASP)
Health Insurance Association of America
Illinois Department of Public Health
Division of Health Education, Indiana State Board of Health
International Association of Lions Clubs
Joint Commission on Sports Medicine and Science
Kansas Department of Health and Environment
Division of Alcohol & Drug Abuse (OPRADA), Louisiana Department of Public Health
March of Dimes Birth Defects Foundation
Massachusetts Department of Public Health, Office for Ron Smoking and Health
Mississippi State Department of Health
Missouri Department of Health
Montana State Department of Health and Environmental Sciences
National Cancer Institute/Smoking, Tobacco & Cancer Branch
Rational 4-H Council
National Association of Elementary School, Principals (NAESP)
National Education Association (NEA), Health Information Network
National High School Athletic Coaches Association
National Institute on Drug Abuse
National Youth Sports Coaches Association (NYSCA)
Nevada State Health Division
Tobacco Use Prevention Program, New Mexico Health & Environmental Dept
New York State Department of Health, Bureau of Adult & Gerontological Health
North Carolina Division of Health Services
North Dakota Department of Health
Health Education & Information Service, Oklahoma State Department of Health
Office on Smoking and Health—Center for Chronic Disease Prevention and Health Promotion—CDC
Commonwealth of Pennsylvania, Department of Health
Society for Adolescent Medicine
STAT—Stop Teenage Addiction to Tobacco
TARGET—of the National Federation of State High School Associations
Office of Smoking & Health, Texas Department of Health
Tobacco Free California, California Medical Association
Utah Department of Health, Tobacco Prevention and Control Program
Vermont Coalition on Cancer Prevention & Control
Women vs Smoking Network
Washington State Department of Health, Office of Heart Disease & Cancer Prevention
Wyoming Division of Health & Medical Services
YMCA of the USA

Fact Sheet on Smoking

- More girls are now smoking than boys, although both are smoking less than they were ten years ago. Among high school seniors, 28.8 percent of males and females smoked daily in 1976. By 1984, the number of seniors who smoked declined to 18.7 percent. Among males, smoking declined from 28.0 percent in 1976 to 16.0 percent in 1984. A smaller decline occurred among females during that period 28.8 percent to 20.5 percent.

- Except for young females, smoking has declined among all major age, race, and sex groups.

- The number of people who have quit smoking is rising steadily. From 1978 to 1986 the ranks of former smokers increased from 31.5 million to more than 37 million.

- Smokers who have quit are less likely to backslide if surrounded by friends who don't smoke.

- The risk of developing lung cancer is ten times greater for smokers than for nonsmokers. Those who smoke two or more packs of cigarettes a day are 15 to 25 times more likely to die of lung cancer than nonsmokers.

- Some 350,000 Americans will die prematurely this year of diseases linked to smoking. That's as many Americans as have been killed in all the wars fought in this century... more than the combined annual death tolls from alcohol, illegal drugs, traffic accidents, suicide, and homicide. That makes smoking the largest preventable cause of illness and premature death in our country. Worldwide, even the most conservative estimates place the number of avoidable deaths caused by smoking at well over one million a year.

- Cigarette smoking has been implicated as a cause of cancer in parts of the body other than the lungs, including the mouth, pharynx, esophagus, bladder, and pancreas. Smoking causes about 30 percent of all cancers.

- Smoking is a major cause of heart disease, emphysema, and chronic bronchitis.

- Fires caused by cigarettes kill more than 2,300 men, women and children each year in the United States. An additional 5,000 victims are burned in cigarette-induced fires each year.

- In 1981 there were 65,000 fires caused by cigarettes that resulted in $300 million in property damage. Local, state, and national fire data all list cigarette-induced fires as the leading cause of fire fatalities.

BEST AVAILABLE COPY

- Pregnant women who smoke have higher rates of miscarriage, stillbirth, premature birth, and complications of pregnancy. More of their babies die soon after birth than the newborns of nonsmoking mothers.

- The six American cigarette companies annually spend more than two billion dollars for advertising on billboards, in newspapers and magazines, and on numerous promotions, many of which are televised.

Source: *Facts and Figures on Smoking 1976-1986*, American Cancer Society

For further information about the AMA "Kids Against Tobacco" (KAT)
Coalition contact: Department of Preventive Medicine
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
(312) 645-5919

Fact Sheet on Passive Smoking

Passive smoking (also called secondhand smoking, sidestream smoking, or involuntary smoking) is the inhalation of the smoke produced by another person's cigarette. The Surgeon General's 1986 *Report on Involuntary Smoking* documents the proven health hazards of involuntary smoking by nonsmokers:

Increased Risk of Cancer

- A study by the Environmental Protection Agency has estimated that 500 to 5,000 nonsmokers die annually of lung cancer caused by others' cigarettes. Even if the lower figure is used, this makes passive tobacco smoke the nation's most lethal airborne carcinogen. The EPA normally regulates air pollution if a substance causes only 20 deaths a year.

- Sidestream smoke contains much higher concentrations of toxic and cancer causing chemicals than the smoke that is inhaled directly. About 75 percent of the nicotine from a cigarette ends up in the atmosphere; only 25 percent enters the smoker's body.

- A study conducted in Japan in 1984 showed that nonsmokers who lived or worked with smokers inhaled significant amounts of nicotine. According to the study, if a nonsmoker's spouse smokes two packs a day, the nonsmoker ends up with the same amounts of cotinine (the breakdown product of nicotine) as someone who smokes up to three cigarettes a day. Other studies have shown that nonsmoking wives of smokers face four times the expected risk of lung cancer and die an average of four years earlier if their husbands are/were longtime smokers.

Other Respiratory Conditions

- A study at the University of California/San Diego found that nonsmokers exposed to secondhand smoke from their colleagues for 20 years had about the same degree of impaired lung function as someone who smoked ten cigarettes a day for 20 years.

- Passive smoking among children of smokers has been found to cause a slower growth of lung volumes and a higher incidence of bronchitis, pneumonia, and other respiratory illnesses.

- It is likely that passive smoking in the workplace increases the risk of acute respiratory disease in nonsmoking adults.

Eye Irritation

- Eye irritation is the most common complaint of healthy people exposed to secondhand smoke.

- Because it delays recovery of vision following glare, exposure to smoke can impair one's driving.

Other Smoke-Related Symptoms

- Passive smokers often experience nasal congestion, headache, cough, sore throat, hoarseness, dizziness, nausea, loss of appetite, fatigue, and irritability.

Aggravation of Existing Health Conditions

- Passive smoking often increases symptoms associated with angina pectoris, asthma, hay fever, emphysema, or other respiratory disease. A Canadian study found that one-fifth of the population had a health condition that was aggravated by exposure to tobacco smoke.

Exacerbated Dangers in Industrial Environments

- Tobacco smoke exacerbates the harmful effects of dangerous physical and chemical agents that may be present in industrial companies.

Forty-three states, the District of Columbia, and more than 400 municipalities now limit or restrict smoking in public places. Thirty-one states have laws restricting smoking in public workplaces; 25 states have comprehensive clean indoor air acts; and 14 states have laws restricting smoking in private workplaces. Thirty-four states have laws restricting smoking in hospitals. Minnesota was the first to enact a statewide law specifically designed to protect nonsmokers from involuntary exposure to cigarette smoke.

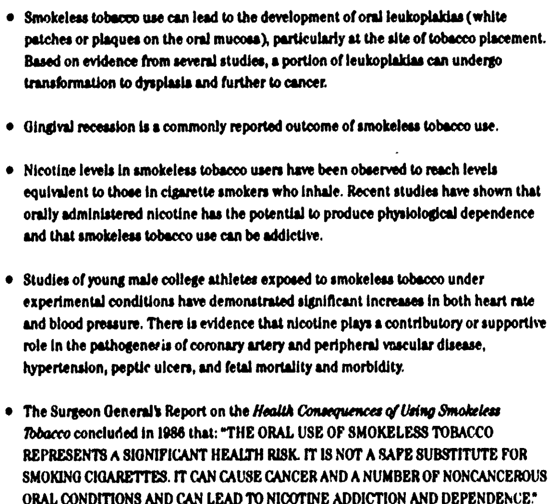
Sources: Bureau of Business Practice, Division of Prentice Hall, Inc., 1987.
American Cancer Society, 1986.
American Medical Association. *Final Report of the Tobacco Use in America Conference*, 1989.

For further information about the AMA "Kids Against Tobacco" (KAT)
Coalition contact: Department of Preventive Medicine
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
(312) 645-5919

Fact Sheet on Smokeless Tobacco

Smokeless tobacco products include both snuff and chewing tobacco. Snuff, which can be either dry or moist, is made from powdered or finely cut tobacco leaves. In some countries, including Great Britain, dry snuff is inhaled, but in the United States, both dry and moist snuff are used predominantly by placing a small amount (pinch) of snuff in the mouth between the lip or cheek and gum. This procedure is commonly referred to as "dipping." Chewing tobacco comes in three forms: the tobacco leaf may be shredded (loose-leaf), pressed in to small bricks (plugs), or dried and twisted into strands (twists). Chewing tobacco can be chewed or held in place in the cheek or lower lip. Both snuff and chewing tobacco are often treated with sweeteners and flavoring agents.

- Use of smokeless tobacco occurs worldwide. Due to fears of the spread of communicable diseases associated with expectoration, use of smokeless tobacco was on the decline until the early 1970s when usage again began to rise sharply.
- Current estimates are that in the United States there are about 12 million people over the age of 12 years who use smokeless tobacco products. Three million of the users are under 21 years of age, and 1.7 million teenage users are between the ages of 12 and 17. The use of smokeless tobacco, particularly moist snuff, is increasing, especially among male adolescents and young male adults.
- Studies of smokeless tobacco use among adolescents have found that the average age of the first use of smokeless tobacco is 10.8 years, and the mean age of initiating regular first use is 12 years. Reasons for initiating use included peer pressure from using friends, curiosity about taste and effects, and use by family members.
- Many adolescent smokeless tobacco users reported that *they believed their habit was a safe alternative to cigarette smoking*. They were able to purchase smokeless tobacco with little difficulty. Discontinuing use was reported to be difficult and frequently unsuccessful.
- There is a strong association between the use of snuff and oral cancer. The excess risk of cancer of the cheek and gum may reach nearly fiftyfold among long term snuff users. Chewing tobacco may also increase the risk of oral cancer.
- Experimental investigations reveal potent carcinogens in smokeless tobacco. These include nitrosamines, polycyclic aromatic hydrocarbons, and radiation-emitting polonium. Tobacco-specific nitrosamines have been detected at levels 100 or more times higher than Government-regulated levels of other nitrosamines permitted in foods eaten by Americans.



- Smokeless tobacco use can lead to the development of oral leukoplakias (white patches or plaques on the oral mucosa), particularly at the site of tobacco placement. Based on evidence from several studies, a portion of leukoplakias can undergo transformation to dysplasia and further to cancer.

- Gingival recession is a commonly reported outcome of smokeless tobacco use.

- Nicotine levels in smokeless tobacco users have been observed to reach levels equivalent to those in cigarette smokers who inhale. Recent studies have shown that orally administered nicotine has the potential to produce physiological dependence and that smokeless tobacco use can be addictive.

- Studies of young male college athletes exposed to smokeless tobacco under experimental conditions have demonstrated significant increases in both heart rate and blood pressure. There is evidence that nicotine plays a contributory or supportive role in the pathogenesis of coronary artery and peripheral vascular disease, hypertension, peptic ulcers, and fetal mortality and morbidity.

- The Surgeon General's Report on the *Health Consequences of Using Smokeless Tobacco* concluded in 1986 that: "THE ORAL USE OF SMOKELESS TOBACCO REPRESENTS A SIGNIFICANT HEALTH RISK. IT IS NOT A SAFE SUBSTITUTE FOR SMOKING CIGARETTES. IT CAN CAUSE CANCER AND A NUMBER OF NONCANCEROUS ORAL CONDITIONS AND CAN LEAD TO NICOTINE ADDICTION AND DEPENDENCE."

Sources: AMA Report of the Board of trustees W (I-87), "Smokeless Tobacco." Public Health Service. *The Health Consequences of Using Smokeless Tobacco: A Report of the Advisory Committee to the Surgeon General*, 1986.

For further information about the AMA "Kids Against Tobacco" (KAT) Coalition contact: Department of Preventive Medicine
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
(312) 645-5919

What You Can do as a Health Care Professional

- If you are a tobacco user, QUIT. Health care professionals are powerful role models for their patients.
- Ask your patients about tobacco use. Tell them about the health effects of tobacco use and urge them to QUIT.
- Make your offices, hospitals, and homes tobacco-free zones. Place signs in prominent places to inform people that tobacco use is not allowed in those areas.
- When you go to restaurants ask for nonsmoking seating. If a restaurant does not have designated nonsmoking areas, LEAVE and tell them why you are leaving. The same can be done when making reservations by telephone.
- Place magazines without tobacco advertising in waiting areas. Some examples of these are: *Good Housekeeping; American Health; Business Week; Health; Harvard Business Review; Modern Maturity; Nation; National Geographic; The New Yorker; Parenting; Reader's Digest; Saturday Evening Post; Science; Smithsonian*, and many more.
- Cancel subscriptions to publications that have tobacco advertising. Send letters along with the notice of cancellation informing the editors and publishers that they are continuing the exploitation of children and youth by advertising addictive drugs—cigarette and tobacco products.
- Adopt a no smoking/no tobacco policy at all professional meetings.
- Become actively involved in making schools and hospitals smoke-free.
- Encourage employers, especially schools and hospitals, to enroll their employees who smoke in smoking cessation programs. Nicotine is one of the most addictive drugs known to man; smokers need help in overcoming this addiction.
- Write letters to legislators urging them to adopt legislation for smoke-free, tobacco-free hospitals, health care institutions, and educational institutions (including medical schools).
- Write letters to legislators urging them to adopt legislation to ban tobacco advertising, particularly in the areas around schools.
- Write letters to legislators urging them to adopt legislation that bans the sale of tobacco products through vending machines.

- Write letters to legislators urging them to ban the distribution of free samples of tobacco products through the mail, on public property, and other places open to the public.

- Work with your professional organization(s) and have it take an antitobacco stand.

- Write letters to legislators urging them to adopt legislation that establishes 21 as the minimum age for purchase of tobacco products. Provisions for strong enforcement should be made that include meaningful penalties for violations.

- Work with national, state and local antitobacco groups to enforce laws prohibiting the sale of tobacco to minors.

- Help to organize antitobacco demonstrations at sporting events that are sponsored by tobacco companies.

Other action ideas:

____

____

____

____

____

____

____

____

For further information about the AMA "Kids Against Tobacco" (KAT)
Coalition contact: Department of Preventive Medicine
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
(312) 645-5919

What You Can do as an Educator

- If you are a tobacco user, QUIT. Educators are powerful role models for their students.
- Ask your students about tobacco use. Include tobacco in your health education curriculum, and tell your students about the health effects of tobacco use. Educate students about prevention and cessation of tobacco use.
- Make your schools, offices, and homes tobacco-free zones. Place signs in prominent places to inform people that tobacco use is not allowed in those areas.
- Place magazines without tobacco advertising in waiting areas. Some examples of these are: *Good Housekeeping; American Health; Business Week; Health; Harvard Business Review; Modern Maturity; Nation; National Geographic; The New Yorker; Parenting; Reader's Digest; Saturday Evening Post; Science; Smithsonian*, and many more.
- Cancel subscriptions to publications that have tobacco advertising. Send letters along with the notice of cancellation informing the editors and publishers that they are continuing the exploitation of children and youth by advertising addictive drugs—cigarette and tobacco products.
- When you go to restaurants ask for nonsmoking seating. If a restaurant does not have designated nonsmoking areas, LEAVE and tell them why you are leaving. The same can be done when making reservations by telephone.
- Adopt a no smoking/no tobacco policy at school related functions.
- Become actively involved in making schools smoke-free.
- Encourage your students to become involved in making school smoke-free through circulating petitions, student council activities, and extra-curricular activities.
- Enroll employees who smoke in smoking cessation programs. Nicotine is one of the most addictive drugs known to man; smokers need help overcoming this deadly addiction.
- Write letters to legislators urging them to adopt legislation for smoke-free, tobacco-free educational institutions.
- Write letters to legislators urging them to adopt legislation to ban tobacco advertising, particularly in the areas around schools.

- Write letters to legislators urging them to adopt legislation that bans the sale of tobacco products through vending machines.

- Write letters to legislators urging them to ban the distribution of free samples of tobacco products through the mail, on public property, and other places open to the public.

- Write letters to legislators urging them to adopt legislation that establishes 21 as the minimum age for purchase of tobacco products. Provisions for strong enforcement should be made that include meaningful penalties for violations.

- Work with national, state and local antitobacco groups to enforce laws that prohibit the sale of tobacco to minors.

- Help to organize antitobacco demonstrations at sporting events that are sponsored by tobacco companies.

Other action ideas:

____

____

____

____

____

____

____

____

For further information about the AMA "Kids Against Tobacco" (KAT)
Coalition contact: Department of Preventive Medicine
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
(312) 645-5919

What You can do as a Parent

- If you are a tobacco-user, QUIT. Parents are powerful role models for their children.
- Ask your children about tobacco use. Tell your children about the health effects of tobacco use and let them know at an early age that you do not approve of tobacco use by children OR adults.
- Make your home a tobacco-free zone. Place signs at entryways and other prominent places to inform people that tobacco use is not allowed in your home.
- When you go out to restaurants ask for nonsmoking seating. If a restaurant does not have designated nonsmoking areas, LEAVE and tell them why you are leaving. The same can be done when making reservations by telephone.
- Work with other parents in your community to develop a directory of restaurants where families can breathe and eat without side-stream smoke.
- Subscribe to magazines without tobacco advertising. Some examples of these are: *Good Housekeeping; American Health; Business Week; Health; Harvard Business Review; Modern Maturity; Nation; National Geographic; The New Yorker; Parenting; Reader's Digest; Saturday Evening Post; Science; Smithsonian*, and many more.
- Cancel subscriptions to publications that have tobacco advertising. Send letters along with the notice of cancellation informing the editors and publishers that they are continuing the exploitation of children and youth by advertising addictive drugs—cigarette and tobacco products.
- Call for a no smoking/no tobacco policy at all school related functions.
- Become actively involved in making schools smoke-free.
- Encourage your children to become involved in making schools smoke-free through circulating petitions, student council activities, and extra-curricular activities.
- Urge schools to enroll employees who smoke in smoking cessation programs. Nicotine is one of the most addictive drugs known to man; smokers need help in overcoming this deadly addiction.
- Write letters to legislators urging them to adopt legislation for smoke-free, tobacco free educational institutions.
- Write letters to legislators urging them to adopt legislation to ban tobacco advertising, particularly in areas around schools.

- Write letters to legislators urging them to adopt legislation that bans the sale of tobacco products through vending machines.

- Write letters to legislators urging them to ban the distribution of free samples of tobacco products through the mail, on public property, and other places open to the public.

- Write letters to legislators urging them to adopt legislation that establishes 21 as the minimum age for purchase of tobacco products. Provisions for strong enforcement should be made, including meaningful penalties for violations.

- Work with national, state and local antitobacco groups to enforce laws that prohibit the sale of tobacco to minors.

- Help to organize antitobacco demonstrations at sporting events that are sponsored by tobacco companies.

Other action ideas:

____

____

____

____

____

____

____

____

For further information about the AMA "Kids Against Tobacco" (KAT)
Coalition contact: Department of Preventive Medicine
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
(312) 645-5919

What You can do as a Legislator

- If you are a tobacco-user, QUIT. Actions speak louder than words to voters.
- Make your office and home tobacco-free zones. Place signs at entryways and other prominent places to inform people that tobacco use is not allowed in your office or home.
- When you go to restaurants ask for nonsmoking seating. If a restaurant does not have designated nonsmoking areas, LEAVE and tell them why you are leaving. The same can be done when making reservations by telephone.
- Refuse campaign contributions from the tobacco industry and subsidiaries.
- Subscribe to magazines without tobacco advertising. Some examples of these are: *Good Housekeeping; American Health; Business Week; Health; Harvard Business Review; Modern Maturity; Nation; National Geographic; The New Yorker; Parenting; Reader's Digest; Saturday Evening Post; Science; Smithsonian*, and many more.
- Cancel subscriptions to publications that have tobacco advertising. Send letters along with the notice of cancellation informing the editors and publishers that they are continuing the exploitation of children and youth by advertising addictive drugs—cigarette and tobacco products.
- Call for a no smoking/no tobacco policy at all legislative functions.
- Support or initiate legislation for smoke-free, tobacco-free educational institutions.
- Support or initiate legislation to ban tobacco advertising, particular in areas around schools.
- Support or initiate legislation that bans the sale of tobacco products through vending machines.
- Support or initiate legislation banning the distribution of free samples of tobacco products through the mail, on public property, and other places open to the public.
- Support or initiate legislation that establishes 21 as the minimum age for purchase of tobacco products. Provisions for strong enforcement should be made that include meaningful penalties for violations.
- Support or initiate legislation requiring improved warning labels on tobacco ads and packages.

- Support or initiate legislation to eliminate federal, state, or local financial support for the growing of tobacco.
- Support or initiate measures to provide federal, state, or local financial assistance for farmers who wish to stop growing tobacco.
- Work with national, state and local antitobacco groups to enforce laws that prohibit the sale of tobacco to minors.
- Support or initiate legislation to ban all tobacco-related advertising in locations where sports are performed.

Other action ideas:

____

____

____

____

____

____

____

____

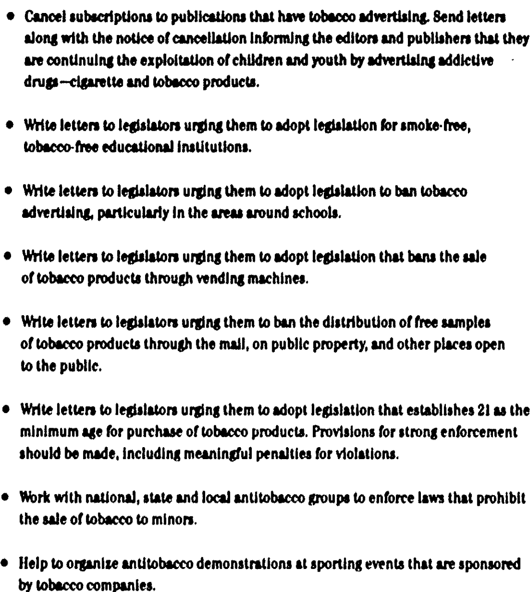
____

For further information about the AMA "Kids Against Tobacco" (KAT)
Coalition contact: Department of Preventive Medicine
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
(312) 645-5919

35-777 O - 91 - 3

What Youth can do Along with Parents and Educators

- If you are a tobacco-user, QUIT. Many of the harmful effects of tobacco use are reversible. Become a positive role model for your peers and for younger kids. Let them know that you care enough about yourself to QUIT.
- Become well informed about the effects of smoking, passive smoking, and smokeless tobacco.
- Help to educate and inform your classmates, friends, and relatives about the harmful effects of tobacco use.
- If your parents, friends, or relatives use tobacco, ask them to QUIT. Tell them that you care about them and that you want them to be around for a long, long time.
- Ask your parents to make your home a tobacco-free zone. Place signs on entryways and in other prominent places to inform people that tobacco use is not allowed in your home.
- Become involved in making schools tobacco and smoke-free by circulating petitions and becoming involved in student council and other extra curricular activities.
- Start a "Kids Against Tobacco" (KAT) Club in your school. Organize poster, tee shirt, and sticker design contests to dramatize the negative effects of tobacco use and/or the positive effects of being tobacco-free.
- Call for a no smoking/no tobacco policy at all school related functions.
- Get copies of your local municipal smoking ordinances. If there are none, attend city/village/town council meetings and call for ordinances that protect nonsmokers from the passive effects of smoking.
- When you go out to restaurants ask for nonsmoking seating. If a restaurant does not have designated nonsmoking areas, LEAVE and tell them why you are leaving. The same can be done when making reservations by telephone.
- Work with other kids/youth in your community to develop a directory of restaurants where families can breathe and eat without side-stream smoke.
- Subscribe to magazines without tobacco advertising. Some examples of these are: *Good Housekeeping; American Health; Business Week; Health; Harvard Business Review; Modern Maturity; Nation; National Geographic; The New Yorker; Parenting; Reader's Digest; Saturday Evening Post; Science; Smithsonian*, and many more.



- Cancel subscriptions to publications that have tobacco advertising. Send letters along with the notice of cancellation informing the editors and publishers that they are continuing the exploitation of children and youth by advertising addictive drugs—cigarette and tobacco products.
- Write letters to legislators urging them to adopt legislation for smoke-free, tobacco-free educational institutions.
- Write letters to legislators urging them to adopt legislation to ban tobacco advertising, particularly in the areas around schools.
- Write letters to legislators urging them to adopt legislation that bans the sale of tobacco products through vending machines.
- Write letters to legislators urging them to ban the distribution of free samples of tobacco products through the mail, on public property, and other places open to the public.
- Write letters to legislators urging them to adopt legislation that establishes 21 as the minimum age for purchase of tobacco products. Provisions for strong enforcement should be made, including meaningful penalties for violations.
- Work with national, state and local antitobacco groups to enforce laws that prohibit the sale of tobacco to minors.
- Help to organize antitobacco demonstrations at sporting events that are sponsored by tobacco companies.

Other action ideas:

____

____

____

For further information about the AMA "Kids Against Tobacco" (KAT)
Coalition contact: Department of Preventive Medicine
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
(312) 645-5919

BEST AVAILABLE COPY

PREPARED STATEMENT OF JONATHAN D. KLEIN

Good Morning, Mr. Chairman. My name is Jonathan Klein, and I am a Clinical Instructor of Pediatrics at the University of North Carolina at Chapel Hill.

It is a privilege to appear before you today on behalf of the American Academy of Pediatrics, whose 39,000 members are committed to the promotion of infant, child and adolescent health.

My colleagues around the country and I are deeply concerned about the serious health hazards to children that result from tobacco smoking. Children who live in homes with smokers are involuntarily exposed to both sidestream smoke (arising from the burning end of a cigarette) and to second-hand smoke (smoke drawn into the respiratory tract of the smoker and then exhaled). This involuntary, or "passive" smoking, results in a variety of health hazards, including more lung infections, more chronic respiratory disease and more lung cancer. The Academy strongly supports legislative initiatives to eliminate or reduce the exposure of children to tobacco smoke, to encourage children not to smoke and to help smokers quit.

PRENATAL EXPOSURE

The hazards of smoking for children begin even before birth. Among women who smoke during pregnancy, there are increased risks of spontaneous abortion and fetal death, and more deaths during the neonatal period. The newborn children of women who smoke during pregnancy are also more likely to show signs of poor intrauterine growth. Elimination of smoking during pregnancy must be part of national and regional efforts to reduce the incidence of infant mortality and low birthweight.

ACUTE HEALTH EFFECTS

Because of their dependence upon adults, children and infants have inescapable risks of smoke inhalation. The involuntary exposure of children to tobacco smoke results in increased frequency of lower respiratory tract infections. Numerous studies have found that bronchitis, otitis media (ear infections), pneumonia and potentially fatal respiratory syncytial virus (RSV) lung infections occur more often in the children of parents who smoke than in the children of parents who do not smoke. Furthermore, the frequency of these respiratory infections increases with the amount of parental smoking; children who live with two adults who smoke have significantly more infections than do children who live with only one adult who smokes. The respiratory problems associated with these exposures result in more disability-days for these children (and thus more out-of-work days for their parents). It also results in more frequent and longer hospitalizations, and higher overall mortality rates for young children who are exposed to involuntary smoke.

Another hazard which the children of smokers along with the smokers themselves face, is that of death or disability due to fire; it has been estimated that cigarettes are the cause of 30–40 percent of all house fires, resulting in an additional several thousand preventable deaths each year.

LONG-TERM HEALTH EFFECTS

Children whose parents smoke also have decreased lung function and decreased lung growth compared with children of non-smoking parents. They have an increased frequency of chronic respiratory symptoms, especially persistent wheezing. Recently published evidence from the Child Health Supplement to the National Health Interview Survey concluded that maternal smoking is associated with higher rates of asthma, an increased likelihood of using asthma medications, and an earlier onset of the disease.

Studies by the National Institutes of Health have also shown a significant relationship between lifetime exposure to passive smoking and overall lung cancer risk. The increased cancer risk was greatest for people whose involuntary exposure to smoke began in childhood and continued through adult life. In addition, although further research will be required to establish these latter associations, involuntary exposure of children to cigarette smoke may also result in a predisposition to the development of chronic obstructive lung disease and ischemic heart disease.

TOBACCO USE BY CHILDREN AND ADOLESCENTS

The United States Surgeon General has estimated that 6 million teenagers smoke, and that another 100,000 children less than 13 years of age also smoke. Young people whose parents smoke are almost twice as likely to smoke cigarettes as those whose parents do not smoke. Many cigarette-advertising campaigns also incorporate

youthful symbols and children's role models, and there is mounting scientific evidence that cigarette advertising and promotion does, in fact, influence young people to smoke.

Smokeless tobacco use (snuff and chewing tobacco) is also increasing among children and adolescents. Smokeless tobacco is a proven human carcinogen, and has a high potential for creating nicotine addiction. Widespread and carefully targeted advertising campaigns promote the mistaken notion that smokeless tobacco is safe. Smokeless tobacco is advertised frequently and has been distributed free of charge to youngsters at sport events and rock concerts. Prominent athletes, musicians and other teenage role-models often are involved in its promotion.

A 1981 report by the Federal Trade Commission concluded that cigarette advertising may be deceptive because its themes and imagery have a capacity or even a tendency to deceive. Many cigarette advertisements attempt to allay public anxieties about the hazards of smoking. Some advertisements associate smoking with good health, athletic vigor, social and professional success, and other attractive ideas. The cigarette is portrayed as an integral part of youth, happiness, attractiveness, personal success and an active, vigorous, strenuous lifestyle. As recently reported by the Centers for Disease Control, the ban on radio and television advertising has resulted in a shift to other promotional devices, including sporting and cultural sponsorship, free samples and discount coupons, and prominent displays in motion picture productions.

Much of the advertising of cigarette companies is directed toward adolescents. Higher excise taxes on cigarettes have been shown to be an effective deterrent in the purchase of tobacco products. Most importantly, research at the University of Michigan has shown that children and youth who smoke are more sensitive to price increases than are adults—adolescents smoke less when the price of a package of cigarettes goes up. Thus, increasing tobacco excise taxes or forcing cigarette manufacturers to bear the full costs of their promotion of death and disease to children, would result in fewer children smoking.

CONCLUSIONS

The Academy encourages pediatricians to support and participate in anti-smoking educational programs in children's schools, and to promote public awareness of the health problems associated with smoking in our communities. However, we also believe that the health hazards of involuntary smoking are of sufficient importance to the health of children that they require national leadership now. The Academy believes that we must do everything possible to try to eliminate or reduce the involuntary exposure of children to tobacco smoke.

Since 1986, the Academy has formally supported a ban on all forms of advertising in all media for all tobacco products. Short of that, we would also support legislative efforts to relieve taxpayers from underwriting the costs of advertising tobacco products. We would also support efforts to eliminate advertising campaigns specifically designed to influence young people to smoke, and eliminate the sale of tobacco products to young people. The Academy further encourages Congress to require counter-advertisements to inform the public of the dangers of tobacco. We also support increases in the Federal excise tax on all tobacco products.

For the protection of the present and future health of the children of this nation, the selling and advertising of all forms of tobacco must be eliminated or controlled without delay. The American Academy of Pediatrics continues to support all efforts to decrease tobacco smoke exposure, and tobacco use, among young people.

Thank you. I would be happy to answer any questions you might have.

Attachments.

American Academy of Pediatrics

"TOBACCO FREE GENERATION"
PROGRAM GOALS
1989-1992

1. To increase awareness of the health hazards of smoking among 5 to 7 year-old children by developing an educational campaign and materials designed to prevent them from ever starting to smoke.

2. To develop educational materials targeted to adolescent smokers, specifically teenage female smokers, to decrease their use of cigarettes.

3. To work with the Provisional Committee on Substance Abuse and the Environmental Hazards Committee to develop and publicize an AAP policy statement advocating completely smoke-free environments in all schools, hospitals and doctors' offices.

4. To develop a plan for AAP chapters to support state laws and regulations to reduce tobacco use, including clean indoor air legislation.

5. To work with the American Lung Association to promote the "Healthy Beginnings" kits, encouraging new parents and health professionals to create smoke-free environments for newborn and young children.

6. To develop office materials for pediatricians to promote non-smoking, and to identify children who smoke or live with smoking family members (e.g., by placing a sticker on their medical chart).

7. To develop a campaign to remove or modify magazines that advertise tobacco products from pediatricians' offices.

8. To provide training and written information for "Tobacco Free" Coordinators on how to conduct smoking cessation classes in the office, and train other pediatricians on how to conduct these classes.

BEST AVAILABLE COPY

Committee on Adolescence

Tobacco Use by Children and Adolescents

(RE7087)

Cigarette smoking is the chief single avoidable cause of death in our society and the most important health issue of our time.[1]

Despite increased public awareness of the long-term morbidity associated with the initiation of cigarette smoking during childhood and adolescence, the 1979 US Surgeon General's report on the health consequences of smoking estimated that 6 million teenagers smoke, and there are another 100,000 youngsters less than 13 years of age who smoke.[2] In 1979, the National Institute of Education reported a fivefold increase in the number of smokers between junior high school- and senior high school-aged students.[3] In 1983, Johnston et al[4] found that 21% of high school seniors were regular daily smokers. Although there has been a general decline of cigarette smoking among male adolescents, there has been no parallel decline in the rate of cigarette smoking among young women, particularly those 17 and 18 years of age (J. A. Califano, Jr, unpublished remarks, 1968, 1974, 1979). Young women who use oral contraceptives are at higher risk of cardiovascular complications if they smoke. Among women who smoke during pregnancy, there is increased risk of poor fetal growth, spontaneous abortion, fetal death, and neonatal death.[5,6]

In addition to the use of cigarettes, the use of "smokeless tobacco," eg, chewing tobacco and snuff, is becoming more common among young people, particularly rural youth. It is estimated that between 10% and 20% of high school students use smokeless tobacco.[7] Its use has been associated with leukoplakia, oral cancer, tooth abrasion, and loss of teeth.[8] There is also a possible association of smoking of clove cigarettes and the occurrence of several illnesses.[9]

Socioeconomic factors are strongly associated with the initiation of cigarette smoking in young people. Young people who are of low socioeconomic status are more likely to commence smoking in high school than are young people of high socioeconomic status.[10] Young people whose parents smoke are almost twice as likely to smoke cigarettes as those whose parents do not smoke (J. A. Califano, Jr, unpublished remarks, 1968, 1974, 1979). The lowest level of cigarette smoking is found among teenagers whose families do not smoke. Peer pressure to initiate smoking can also affect the decision to smoke.[11] Many cigarette-advertising campaigns incorporate youthful symbols and role models, and there is some evidence that cigarette advertising and promotion does, in fact, influence young people to smoke.[12,13]

ROLE OF THE PEDIATRICIAN

The pediatrician can assume a leadership role in both primary and secondary prevention of smoking. Primary prevention assists children and adolescents in resisting the temptation to commence cigarette smoking. Secondary prevention emphasizes the reasons to stop smoking and encourages young people to actually stop.

Approaches that focus on the maintenance of health and on physical competence are more effective than those that address long-term risks which may occur many years hence. Most children and adolescents do not think ahead until well into their adolescence, and even then, if they understand the long-term morbidity of smoking, they may deny the risks of smoking during their adolescence. Institutional and social support for nonsmoking is also critical for the maintenance of nonsmoking among our young people.

The major settings in which the primary and secondary prevention of smoking can be practiced by the pediatrician are (1) the office/clinic, (2) the school/community, (3) the home, and (4) the media.

Office/Clinic

The environment of the office can provide the opportunity for the pediatrician to communicate attitudes about smoking. By *not* smoking, the pediatrician can serve as a role model for others to emulate. Smoking by the staff, the adolescents, or the parents should not be allowed in the pediatric offices or waiting areas. Nonsmoking signs and

This statement has been approved by the Council on Child and Adolescent Health.
PEDIATRICS (ISSN 0031 4005). Copyright © 1987 by the American Academy of Pediatrics

ample literature about the problems associated with smoking can be displayed.

Pediatricians should routinely take a history of smoking and other tobacco use from children and adolescents. If the young person has initiated smoking, a discussion about the maintenance of optimal health should be undertaken. Exploration of the adolescent's knowledge concerning the effects of smoking on health could be developed. These discussions should be directed toward the adolescent's cognitive level. Because normal adolescents are concerned about their body and its appearance, the issues of tooth staining, mouth odor, and decreased stamina from smoking can be emphasized. In addition, adolescents should be assisted with developing the skills to resist smoking pressure and/or stop smoking.

Counseling the parents about their own smoking habits and those of their children also allows another avenue for discussion. All families, especially those in which there is a strong history of lung and/or cardiovascular conditions, should be made fully aware of the particular hazards of cigarette smoking. Referrals to support groups or other community organizations for smoking cessation should be made.

School/Community

Schools, churches, and recreation facilities are ideal settings in which to integrate smoking education and health education. There is ample literature available indicating that educational programs in the schools such as didactic sessions and counseling,[14] *skills intervention*,[18] and awareness of the health problems associated with smoking all have short-term effects in preventing smoking. Because most young people will have their initial experience with smoking prior to high school, educational endeavors need to be initiated at early grade levels.

The pediatrician should act as an advocate for such programs and, if possible, participate in their development and/or teaching. Assistance can be given to help nonsmoking teenagers speak up for their rights to a smoke-free environment and toward a total ban on tobacco use in schools.The pediatrician could work closely with health education teachers, physical education teachers, trainers, and science teachers in the preparation of such programs. The pediatrician has many opportunities to influence local school boards and governing bodies in their policy decisions affecting cigarette smoking among adolescents and adults. Leadership is needed to support restriction of the sale of tobacco products to young people through retail outlets and vending machines and through the elimination of local advertising campaigns that seem likely to influence young people to start smoking.

Home

Every effort should be made to encourage smoking parents to relinquish their habit, not only for their own sake but for the health of their children, because of the known effects of passive smoking[16] and because of their role modeling as well. This intervention should be considered throughout the pediatrician-family relationship as the pediatrician is the advocate for healthy families as well as healthy children.

Media

The prevention of children's smoking is a constant goal of the pediatrician. With the initiation of tobacco use currently in late childhood and early adolescence, pediatricians should support efforts to prevent advertising of all tobacco products. The pediatrician can play a leading role in the elimination of advertising campaigns that seem likely to influence young people to start smoking. At times, cigarette advertisements attempt to allay anxieties about the hazards of smoking. Some advertisements associate smoking with good health, athletic vigor, social and professional success, and other attractive ideas. "The cigarette is portrayed as an integral part of youth, happiness, attractiveness, personal success and an active, vigorous, strenuous lifestyle."[13]

During the past decade, some progress has been made in reducing the numbers of persons who smoke cigarettes. Pediatricians should be at the forefront of encouraging optimal child and adolescent health by becoming leaders in discouraging cigarette smoking in these vulnerable groups. The American Academy of Pediatrics continues to support the efforts of pediatricians to decrease tobacco use among young people—a major health issue of our time.

COMMITTEE ON ADOLESCENCE, 1985-1987
Joe M. Sanders, Jr, Chairman, MD
Roberta K. Beach, MD
Richard R. Brookman, MD
Richard R. Brown, MD
John W. Greene, MD
Elizabeth McAnarney, MD
S. Kenneth Schonberg, MD

Liaison Representative
Philip Goldstein, MD, American College of Obstetricians and Gynecologists

AAP Section Liaison
George D. Comerci, MD, Section on Adolescent Health

REFERENCES

1. Brandt EN Jr: *The Health Consequences of Smoking—A Report of the Surgeon General.* (Report to Congress from the US Department of Health and Human Services, 1982)
2. US Surgeon General: *The Health Consequences of Smoking,* 1979, in Taylor P (ed): *The Smoking Ring: Tobacco, Money, and International Politics.* New York, Pantheon, 1984, p 222
3. Perry C, Killen J, Telch M, et al: Modifying smoking behaviors of teenagers: A school-based intervention. *Am J Public Health* 1980;70:722-725
4. Johnston L, O'Malley P, Bachman L: *Highlights from Drugs and American High School Students,* 1975–1983. Bethesda, MD, National Institute on Drug Abuse, 1984
5. US Surgeon General: The Health Consequences of Smoking for Women: A Report of the Surgeon General. Washington DC, US Department of Health and Human Services, 1980, p 238
6. Miller HC, Merritt TA: *Fetal Growth in Humans.* Chicago: Year Book Medical Publishers, 1979
7. *Summary of Evidence and Findings and Conclusions Concerning the Adverse Health Effects of Snuff.* Boston, Massachusetts Department of Public Health, 1985, p 10
8. International Medical News Service: Warning labels considered for chewing tobacco, snuff. *Pediatric News* March 1985, p 26
9. *Centers for Disease Control:* Illness possibly associated with smoking clove cigarettes. *MMWR* 1985;34:297-298
10. Eckert P: Beyond the statistics of adolescent smoking. *Am J Public Health* 1983;73:439–441
11. Evans RJ: Smoking in children. *J Prevent Med* 1976;5:122
12. Federal Trade Commission, *Report to Congress Pursuant to the Cigarette Smoking Act for the Year.* Washington, DC, 1976, p 4
13. Federal Trade Commission, *Staff Report on the Cigarette Advertising Investigation.* Washington, DC, 1981, pp 2-8
14. Midanik LT, Polen MR, Hunkeller EM, et al: Methodologic issues in evaluating stop-smoking programs. *Am J Public Health* 1985;75:634–638
15. Schinke SP, Gilchrist LD, Snow WH: Skills intervention to prevent cigarette smoking among adolescents. *Am J Public Health* 1985;75:665–667
16. Friedman GB, Petitti DB, Bawol RD: Prevalence and correlates of passive smoking. *Am J Public Health* 1983;73:401

Committee on Environmental Hazards

Involuntary Smoking—A Hazard to Children

(RE6057)

Children who live in households with smokers are involuntarily exposed to sidestream and secondhand cigarette smoke. The health hazards that result from passive smoking will be reviewed. This statement updates a 1982 American Academy of Pediatrics statement on the environmental consequences of tobacco smoking.[1]

COMPOSITION OF SIDESTREAM AND SECONDHAND SMOKE

Sidestream smoke arises from the burning end of a cigarette.[2,3] Secondhand or exhaled mainstream smoke is drawn into the respiratory tract of the smoker and then is exhaled. Both sidestream and secondhand smoke contain measurable quantities of such toxins as carbon monoxide (CO), ammonia, nicotine, and hydrogen cyanide. They also contain carcinogens, including benzo[*a*]pyrene, dimethylnitrosamine, tar, formaldehyde, and β-naphthylamine.[2] Concentrations of most of these materials are higher in sidestream than in mainstream smoke.[2] Air-sampling surveys have documented the involuntary exposure of nonsmokers to the products of cigarette combustion.[2,3] These studies have shown that smoking in enclosed rooms can produce CO levels greater than the national ambient air quality standard of 9 ppm.[4] Similarly, elevated concentrations of airborne nicotine, benzo[*a*]pyrene, and suspended particulates have been documented.[4]

Biologic evaluations of nonsmokers involuntarily exposed to cigarette smoke have demonstrated elevations of 1% to 3% in carboxyhemoglobin concentration.[5] Biologic evaluations of involuntary smokers have also found increased levels of nicotine and of cotinine,[6,7] the major metabolite of nicotine, in the urine and saliva. In addition, studies have demonstrated increased activity of enzymes that metabolize benzo[*a*]pyrene in the placentas of women who smoke[8] and, possibly, in the placentas of women involuntarily exposed to cigarette smoke.[9] Finally, increased urinary excretion of mutagens has been found in involuntary smokers.[10]

PEDIATRICS (ISSN 0031 4005). Copyright © 1986 by the American Academy of Pediatrics.

SIZE OF THE EXPOSED POPULATION

No firm estimates of the number of American children involuntarily exposed to cigarette smoke are available. However, recent surveys have found that 53% to 76% of the homes in the United States contain at least one smoker.[3] Application of these rates to the 1980 US Census indicates that between 8.7 and 12.4 million American children less than 5 years of age are exposed to cigarette smoke in their homes. Because smoking is most common in families of lower socioeconomic status,[11] involuntary smoking occurs more frequently among children in such families.

ACUTE HEALTH EFFECTS OF INVOLUNTARY SMOKING

Bronchitis, pneumonia, and respiratory syncytial virus (RSV) infection have all been found to occur more often in the children of parents who smoke than in the children of parents who do not smoke.[12,13] Furthermore, the frequency of these respiratory infections have been found to increase with the amount of parental smoking; children with two parents who smoke have significantly more infections than children with only one parent who smokes. Maternal smoking relates more closely to childhood respiratory infection than paternal smoking. The association between parental smoking and childhood respiratory infection is most strongly evident during the first 1 to 2 years of life and diminishes thereafter.[14-16]

Respiratory symptoms, persistent wheeze in particular, have also been reported to be more frequent in children whose parents smoke than in children whose parents do not smoke.[11,17-20] The frequency of these symptoms increases with the number of parents who smoke. The association is strongest in the first year of life.[21]

LONG-TERM HEALTH EFFECTS OF INVOLUNTARY SMOKING

Children of parents who smoke have been found to have small, but significant, decreases in pulmo-

nary function compared with children whose parents do not smoke.[17,18,22-24] These deficits are primarily obstructive and are manifest either by decreased forced expiratory volumes ($FEV_{1.0}$ or $FEB_{0.75}$) or decreased forced expiratory flow (FEF_{25-75}). These effects are more closely related to maternal than to paternal smoking. Several studies have suggested there is a dose-response relationship between the number of smokers in the home and the degree of obstructive impairment. Functional deficits appear to be more serious in younger than in older children.

Longitudinal follow-up of children whose parents smoke indicates that their annual rate of lung growth is significantly less than expected.[17,25] The subsequent failure of such children to attain their full, genetically determined level of pulmonary function may predispose them to chronic obstructive lung disease and premature pulmonary failure.

INVOLUNTARY SMOKING AND LUNG CANCER

Several studies have evaluated the association between involuntary smoking and lung cancer. A case-control study in Greece[26,27] and a longitudinal prospective study in Japan[28] both found a statistically significant association between the occurrence of lung cancer in nonsmoking women and smoking by their husbands. In both studies, the wives' risk of lung cancer increased two- to threefold according to the amount of the husband's smoking; in both studies, dose-response relationships were evident between the amount of involuntary exposure to smoke and cancer mortality.[26-28] However, a study by the American Cancer Society failed to find a statistically significant increase in lung cancer in the nonsmoking wives of husbands who smoked, although that study did observe a nonsignificant trend in lung cancer mortality.[29] Finally, recent studies from the National Institutes of Health have observed a positive association between cumulative lifetime exposure to passive smoking and overall cancer risk.[30-33] Cancer risks were greatest for persons whose involuntary exposure to smoke began in childhood and continued through adult life.

INVOLUNTARY SMOKING AND ISCHEMIC HEART DISEASE

A recent study of older adults found that the nonsmoking wives of men who smoked had a higher age-adjusted death rate from ischemic heart disease than did women whose husbands had never smoked.[34] This difference remained evident after adjustment of the data for differences in cardiac risk factors.

CONCLUSIONS

The involuntary exposure of children to tobacco smoke results in increased frequency of lower respiratory tract infections, increased frequency of respiratory symptoms, decreased pulmonary function, and decreased lung growth. In addition, involuntary exposure of children to cigarette smoke may result in predisposition to the development of chronic obstructive lung disease, lung cancer, and ischemic heart disease. Although further research will be required to establish these associations, all are biologically plausible consequences of involuntary smoking. Furthermore, all are of sufficient importance to children's future health that they demand prudent preventive action even in the absence of complete evidence on causality.

RECOMMENDATIONS

Vigorous and immediate action is required to reduce the involuntary exposure of children to tobacco smoke. Because the determinants of passive smoking are manifold, a successful strategy to reduce passive smoking must consist of several complementary elements:

1. Pediatricians should seek a history of involuntary exposure to tobacco smoke whenever they encounter a child with lower respiratory tract infection, persistent respiratory symptoms, or unexplained alterations in lung function.[2]

2. Pediatricians must increase their efforts to inform both patients and parents about the hazards of tobacco.[1]

3. Pediatricians should set an example by not using tobacco products.[1]

4. Pediatricians should take the lead in urging that (*a*) sales of all tobacco products be banned in all pediatric hospitals and in other facilities caring for children[35] and (*b*) cigarette smoking be banned in all such facilities, except in certain designated areas.[36]

5. Pediatricians and Academy chapters should urge their state and local governments to consider passage of clean indoor air legislation. Such legislation prohibits all indoor smoking, except in areas where it is specifically permitted; this legislation has been passed successfully in several states.[37,38]

6. Pediatricians and Academy chapters should encourage the Congress and the Federal Trade Commission to (*a*) ban all advertising in all media for all tobacco products[39,40]; (*b*) sponsor counter-advertisements, particularly on television, to inform the public of the dangers of tobacco; (*c*) strengthen the health warnings that appear on cigarette packages; such messages should specifically warn of the hazards of involuntary smoking; and (*d*) increase the federal excise tax on all tobacco products. Higher excise taxes have been shown to be an effective deterrent in the purchase of tobacco.[41]

7. Pediatricians and Academy chapters should urge Congress to dismantle the tobacco price support program.[1]

Committee on Environmental Hazards, 1984-1985
Philip J. Landrigan, MD, Chairman
John H. DiLiberti, MD
John W. Graef, MD
Richard J. Jackson, MD
Gerald Nathenson, MD

Liaison Representatives
Henry Falk, MD
Robert W. Miller, MD
Walter Rogan, MD
Diane Rowley, MD

Section Liaison
Audrey K. Brown, MD

REFERENCES

1. American Academy of Pediatrics, Committee on Genetics and Environmental Hazards: The environmental consequences of tobacco smoking: Implications for public policies that affect the health of children. *Pediatrics* 1982;70:314-315
2. *The Health Consequences of Smoking—A Report of the Surgeon General*, chapter 7: Passive Smoking. US Department of Health and Human Services, Public Health Service, 1984
3. National Research Council: *Indoor Pollutants*. Washington, National Academy Press, 1981
4. US Department of Health, Education, and Welfare, Public Health Service/Centers for Disease Control. Highlights of the Surgeon General's report on smoking and health. *MMWR* 1979;28:1-11
5. Huch R, Danko J, Spatling L, et al: Risks the passive smoker runs. *Lancet* 1980;2:1376
6. Greenberg RA, Haley NJ, Etzel RA, et al: Measuring the exposure of infants to tobacco smoke: Nicotine and cotinine in urine and saliva. *N Engl J Med* 1984;310:1075-1078
7. Matsukura S, Taminato T, Kitano N, et al: Effects of environmental tobacco smoke on urinary cotinine excretion in non-smokers: Evidence for passive smoking. *N Engl J Med* 1984;311:828-832
8. Welch RM, Harrison YE, Conney AH, et al: Cigarette smoking: Stimulatory effect on metabolism 3,4-benzopyrene by enzymes in human placenta. *Science* 1968;160:541-542
9. Manchester DK, Jacoby EH: Sensitivity of human placental monooxygenase activity to maternal smoking. *Clin Pharmacol Ther* 1981;30:687-692
10. Bos RP, Theuws JLG, Henderson PTH: Excretion of mutagens in human urine after passive smoking. *Cancer Lett* 1983;19:85-90
11. Covey LS, Mushinski MH, Wynder EL: Smoking habits in a hospitalized population: 1970-1980. *Am J Public Health* 1983;73:1293-1297
12. Colley JRT, Holland WW, Corkhill RT: Influence of passive smoking and parental phlegm on pneumonia and bronchitis in early childhood. *Lancet* 1974;2:1031-1034
13. Pullan CR, Hey EN: Wheezing, asthma, and pulmonary dysfunction 10 years after infection with respiratory syncytial virus in infancy. *Br Med J* 1982;284:1665-1669
14. Harlap S, Davies AM: Infant admissions to hospital and maternal smoking. *Lancet* 1974;1:529-532
15. Fergusson DM, Horwood LJ, Shannon FT, et al: Parental smoking and lower respiratory illness in the first three years of life. *J Epidemiol Commun Health* 1981;35-180-184
16. Schenker MB, Samet JM, Speizer FE: Risk factors for childhood respiratory disease: The effect of host factors and home environment exposures. *Am Rev Respir Dis* 1983;128:1038-1043
17. Ware JH, Dockery DW, Spiro A III, et al: Passive smoking, gas cooking, and respiratory health of children living in six cities. *Am Rev Respir Dis* 1984;129:366-374
18. Weiss ST, Tager IB, Speizer FE, et al: Persistent wheeze: Its relation to respiratory illness, cigarette smoking, and level of pulmonary function in a population sample of children. *Am Rev Respir Dis* 1980;122:697-707
19. Lebowitz MD, Burrows B: Respiratory symptoms related to smoking habits of family adults. *Chest* 1976;69:48-50
20. Dodge R: The effects of indoor pollution on Arizona children. *Arch Environ Health* 1982;37:151-155
21. Pedreira FA, Guandolo VL, Feroli EJ, et al: Involuntary smoking and incidence of respiratory illness during the first year of life. *Pediatrics* 1985;75:594-597
22. Tashkin DP, Clark VA, Simmons M, et al: The UCLA population studies of chronic obstructive respiratory disease: VII. Relationship between parental smoking and children's lung function. *Am Rev Respir Dis* 1984;129:891-897
23. Vedal S, Schenker MB, Samet JM, et al: Risk factors for childhood respiratory disease: Analysis of pulmonary function. *Am Rev Respir Dis* 1984;130:187-192
24. Tager IB, Weiss ST, Rosner B, et al: Effect of parental cigarette smoking on the pulmonary function of children. *Am J Epidemiol* 1979;110:15-26
25. Tager IB, Weiss ST, Munoz A, et al: Longitudinal study of the effects of maternal smoking on pulmonary function in children. *N Engl J Med* 1983;309:699-703
26. Trichopoulos D, Kalandidi A, Sparros L, et al: Lung cancer and passive smoking. *Int J Cancer* 1981;27:1-4
27. Trichopoulos D, Kalandidi A, Sparros L: Lung cancer and passive smoking: Conclusion of Greek study. *Lancet* 1983;2:677-678
28. Hirayama T: Non-smoking wives of heavy smokers have a higher risk of lung cancer: A study from Japan. *Br Med J* 1981;282:183-185
29. Garfinkel L: Time trends in lung cancer mortality among nonsmokers and a note on passive smoking. *JNCI* 1981;66:1061-1066
30. Correa P, Pickle LW, Fontham E, et al: Passive smoking and lung cancer. *Lancet* 1983;2:595-597
31. Sandler DP, Everson RB, Wilcox AJ: Passive smoking in adulthood and cancer risk. *Am J Epidemiol* 1985;121:37-48
32. Sandler DP, Wilcox AJ, Everson RB: Cumulative effects of lifetime passive smoking on cancer risk. *Lancet* 1985;1:312-315
33. Sandler DP, Everson RB, Wilcox AJ, et al: Cancer risk in adulthood from early life exposure to parents' smoking. *Am J Public Health* 1985;75:487-492
34. Garland C, Barrett-Connor E, Suarez L, et al: Effects of passive smoking on ischemic heart disease mortality of nonsmokers: A prospective study. *Am J Epidemiol* 1985;121:645-650
35. The American Public Health Association: Cigarette sales and smoking in pharmacies, health facilities and health agencies. *Am J Public Health* 1985;75:300
36. Hall FM: Smoking in the physician's work place. *N Engl J Med* 1985;312:1197-1198
37. Kahn PL: The Minnesota clean indoor air act: A model for New York and other states. *NY State J Med* 1983;83:1300-1301
38. Tate CF Jr: A physician-led referendum for cleaner air in Florida. *NY State J Med* 1983;83:1302
39. Warner KE: Cigarette advertising and media coverage of smoking and health. *N Engl J Med* 1985;312:384-388
40. Koop CE: A dialogue with Surgeon General Koop: Confronting America's most costly health problem (interview by Alan Blum). *NY State J Med* 1983;83:1260-1263
41. Warner KE: Cigarette taxation: Doing good by doing well. *J Public Health Policy* 1984;5:312-319

BEST AVAILABLE COPY

PREPARED STATEMENT OF SENATOR FRANK R. LAUTENBERG

Mr. Chairman, I commend you for holding this hearing and thank you for the chance to testify.

Mr. Chairman, I know that part of the mission of your Committee is to address pressing health care issues. I commend the Chairman for focusing this hearing on smoking and health. One of the principal problems plaguing our society is the cost to the health care system from tobacco addicted Americans. Each year cigarette smoking costs our economy $65 billion annually in health care costs and lost productivity. Cigarette smoking costs the Medicaid and Medicare programs. It impacts on private health insurance plans.

The need to look at the impact of smoking on health care costs couldn't be greater. And the place to begin an examination of this issue is with our young people. If we can prevent our young people from getting hooked on tobacco products, we can save countless lives and billions of dollars in health care costs for the American people down the road.

Right now we are losing the battle to prevent our kids from smoking. The facts speak for themselves. According to the Surgeon General's 1989 report, approximately 80% of smokers started before the age of 21. One out of four high school seniors who has ever smoked began when he was 12 years old. The earlier a young person begins using tobacco, the harder it is for them to kick the habit.

As more and more people quit smoking, the tobacco industry has stooped lower and lower in order to keep their cash registers ringing.

Just to replace those smokers who quit, the tobacco industry needs to hook 6000 new smokers a day according to the Coalition on Smoking or Health. And where does the industry turn for its profits? It turns to the disadvantaged and to minorities. "Uptown"—the cigarette the industry planned to test market to blacks in Philadelphia—was among the most blatant of its racial appeals. The industry turns its guns on female teenagers. Dakota is the kind of product they'd sell. And, most reprehensible of all, the industry has targeted our kids.

The tobacco industry says it doesn't want kids to smoke. It says it doesn't try to lure minors into a life-time of smoking.

But the tobacco industry's actions are just the opposite of what it purports are its aims.

The tobacco industry's voluntary code says the industry will not use sports or celebrity testimonials that have a special appeal to persons under 21 years old. Yet the industry continues to sponsor the Virginia Slims Tennis Tournament, the Marlboro Grand Prix and other sporting events that attract *millions* of young people. It continues to hope that young television viewers will see their athletic heroes and tobacco company logos side by side on the t.v. screen.

The tobacco industry's voluntary code says cigarette advertising will not suggest that smoking is essential to social prominence, distinction, success or sexual attraction, and that it will not picture a person smoking in an exaggerated manner. But cigarette ads suggest *all* of these things—like these recent Camel ads in Sports Illustrated and People magazine.

The tobacco industry's voluntary code says free cigarette samples will not be given to any person who is known to be younger than 21 years old. Yet minors receive advertisements in the mail that offer them free packs of cigarettes. Young people are approached on the street and offered free cigarette samples.

The tobacco industry tries to lure our young people into smoking with all kinds of flashy gimmicks. It gives away free t-shirts that appeal to young people. It gives away cartoon posters that appeal to young people. Tobacco companies don't mind having their brand name ripped off to sell candy cigarettes to adolescents.

Mr. Chairman, for too long our government has been complacent about the numbers of young people that are taking up smoking. For too long it sat on the sidelines and watched tobacco products slowly suck the life out of our citizens. We can no longer sit idly by while tobacco companies cynically devise marketing campaigns to lure our most vulnerable people—particularly our children—into a life of nicotine addiction.

We need to fight back.

In many ways, the fight against tobacco addiction among our young people is like the fight against drug addiction. Drugs are addictive. But tobacco may be more so. Drugs are fatal. So is tobacco. It leads to cancer and lung disease and heart disease. We know that it takes nearly 400,000 precious American lives each year. And we know that it costs us billions annually in lost productivity and health care costs resulting from sickness or disease related to cigarette smoking.

We're fighting an all out war to keep our kids off *drugs*. We've targeted resources for *drug* education. We've appointed a Federal *drug* czar. And we're trying to get more money into our cities and states to fight *drug* abuse.

But what have we done to keep our kids away from tobacco? What have we done to prevent our children from taking an often fatal first puff and becoming addicted for life?

Not enough.

We see 11, 12, and 13 year olds smoking cigarettes in our schools and shopping malls, but the Federal Government hasn't made a concerted effort to stop it. We see 9 year old kids buying cigarettes from vending machines and in our stores, but we haven't acted to prevent it. We see children being given free cigarette samples, but we haven't insisted that it stop.

If we saw a 10 year old child holding a gun to his head, surely we'd intervene to save that young child's life.

We should have the same reaction when it comes to our kids smoking cigarettes. We need to act aggressively and intervene to prevent young kids from getting hooked.

I have introduced legislation, the Adolescent Tobacco Prevention Act, that would create two new incentive grant programs to encourage states to enact and enforce laws to limit youth access to tobacco products. The bulk of that legislation has been incorporated into the "Tobacco Education and Control Act of 1990," which was reported out of the Senate Labor and Human Resources Committee last week.

The Adolescent Tobacco Prevention Act would create incentive grants for states that enact *and enforce* laws prohibiting the sale of tobacco products to a minor under the age of 18. States that already have laws on the books would be given an incentive to enforce those laws. States would be encouraged to prohibit the distribution of free cigarette samples. The bill would also create an incentive grant program to get states to make elementary and secondary schools smoke-free.

Under the bill, states would be encouraged to ban the sale of tobacco products in vending machines except in areas such as bars and nightclubs where minors are not permitted. The ability of young people to purchase cigarettes through vending machines is inextricably linked to enforcement of minimum age laws. If we are going to expect merchants to respect minimum age laws, it doesn't make sense to provide minors with access to tobacco products from vending machines. Now, merchants can point to unrestricted vending machine sales of tobacco products as a reason for continuing to sell tobacco products to a minor. We need to eliminate this disincentive.

The need to act quickly and decisively to discourage young people from taking up smoking couldn't be greater. The Federal Government needs to fight back to prevent young people from taking a fatal first puff and becoming hooked for life. The Federal Government needs to make a concerted effort to get the truth out—especially to young people—about the grave health consequences of smoking tobacco.

And the truth is that smoking tobacco kills.

Prepared Statement of Robert J. Myers

Mr. Chairman and Members of the Committee: My name is Robert J. Myers. I served in various actuarial capacities with the Social Security Administration and its Predecessor agencies during 1934-70, being Chief Actuary for the last 23 of those years. In 1981-82, 1 was Deputy Commissioner of Social Security, and in 1982-83, I was Executive Director of the National Commission on Social Security Reform. Currently, I am Chairman of the Commission on Railroad Retirement Reform.

My testimony will first deal with my recent study on the effect of smoking on mortality of men aged 30 and over. Then, I will relate the findings therefrom to tie cost aspects of the Medicare and Social Security programs.

RESULTS OF THE STUDY

Over the past several years, I have participated in a study of the effect of cigarette smoking of males aged 30 and over. Gus H. Miller, Ph.D, Director, Studies on Smoking, Edinboro, Pennsylvania, collected survey data as to the lifetime smoking habits of men who died in Erie County, Pennsylvania in 1972-74, and corresponding data on the smoking habits of men who lived in the county in the same period. My role in the study was to apply standard actuarial techniques to these data, so as to obtain figures about relative life expectancies.

Although other mortality studies relating to the effect of smoking have been made, this one was unique in its procedure of combining data from a deceased population with those from the living population which was exposed to the risk of death.

This procedure was followed in just the same manner as population life tables are developed at the time of each decennial census. Other studies have used the cohort method of following through a group of individuals over a long period of years and thus have the disadvantage of long delays being involved before final results could be obtained.

Our study was published in the May/June issue of *Contingencies* (published by the American Academy of Actuaries), a copy of which paper is attached to my testimony.

The study compares the experience of men who were lifetime smokers with that of men who had never smoked, and thus does not deal with the considerable, intermediate, and non-homogeneous group who had smoked significantly for some time, but had ceased later.

In brief, the expectation of life at age 30 for nonsmokers was found to be 52.7 years (i.e., living to an average age of 82.7), as against an expectation of life for smokers of only 34.8 years (i.e., living to age 64.8). Similar differentials apply for other attained ages. For example, at age 65, nonsmokers were found to have a life expectancy of 18.3 years, or somewhat more than double the 8.3 years for smokers.

CONCLUSIONS TO BE DRAWN FROM STUDY

First, I must say that I was quite surprised, after I had made my analysis, that the mortality differential was so large as between nonsmokers and smokers. I well recognize that there could be other elements involved here besides the matter of smoking. It could well be that persons who refrain from smoking during their entire lifetimes have other personal characteristics which produce low mortality.

It is not possible to conduct an experiment with human beings in the same manner as with laboratory animals or chemical test tubes. Thus, we cannot validly draw the conclusion that, for a specific individual aged 30 who is deciding whether to begin lifetime cigarette smoking, life expectancy will be about 18 years lower if he does so. Nonetheless, with such a large differential in life expectancy as shown by my data, it seems reasonable and objective to conclude that smoking will, on the average, have a very significant deleterious effect on life expectancy.

COST EFFECTS OF SMOKING ON MEDICARE

Let me next consider the cost effects that smoking may have on the Medicare program. Based on the hypothesis and conclusion that mortality rates are significantly increased by smoking, as indicated previously, it seems reasonable to assert that medical costs for smokers will occur earlier than for nonsmokers, particularly as to those costs related to terminal illnesses. It is, of course, recognized that all nonsmokers will have terminal illnesses, but the costs therefore will be delayed considerably longer, on the average, than those of smokers. As a result, if there were the higher mortality rates associated with smoking, terminal-illness medical costs would be delayed considerably into the future, and people would have lower average annual costs. As a result, the Medicare program would be favorably affected, at least from a cash-flow standpoint.

Although academicians may attempt to quantify the cost effects on the Medicare program associated with the effects of smoking, I believe that this cannot be done with any accuracy or precision. Too many disparate assumptions are involved, and the arbitrary choices among them can make great differences in the results—even though these results may seem to be very accurate because they are derived from elegant mathematical computations and elaborate computer printouts. Under some circumstances, smoking can save money for the Medicare program—for example, if the individual involved dies before age 65 and is not disabled before death long enough to meet the 2½-year disability requirement for Medicare eligibility, as against living beyond age 65 if smoking were not involved and then having Medicare pick up the "normal" final-illness costs. Nonetheless, I cannot overemphasize the fact that elimination of smoking would very significantly lower the cost of the Medicare program in the aggregate, even though not necessarily so for every covered individual involved.

COST EFFECTS OF SMOKING ON SOCIAL SECURITY

In recent years, several academic studies have been made as to the effect of smoking on the cost of the Social Security program (Old-Age, Survivors, and Disability Insurance). On the whole, these studies came to the over-simplified, naive conclusion that reduction in smoking, along with the concomitant increase in longevity, would have significant adverse effects on the financial status of the Social Security program. This conclusion has apparently been based on the fact that people would live

longer in retirement, and therefore benefit outgo would be increased. Generally ignored was the resulting lower cost for disability and survivor benefits if reduction in smoking resulted in lower morbidity and mortality.

Once again, I am constrained to say that it is impossible to take into account all of the many important elements that are involved in attempting to foretell what would occur in the society and the economy when reduction in smoking would produce lower mortality. For example, not only would disability and survivor benefits have lower costs, but also people might work longer and retire later, which would reduce costs.

There is no doubt that, all other things being equal, the reduction in mortality resulting from reduced smoking would increase the cost of the retirement benefits under the Social Security program. However, would any humane person argue that therefore we should not only not try to discourage smoking, but rather should encourage it? This approach would follow the reputed retirement procedure among Eskimos—namely, putting the retiree outside of the igloo.

SUMMARY

The very desirable overall results of reducing morbidity and mortality by lessening smoking are obvious. Certainly, under such circumstances, the cost of the Medicare program would be substantially reduced. On the other hand, the cost of the Social Security program would be increased. However, the overriding element is the improvement of health and life style Chat would result. And it could well be that the increase in cost of the Social Security program would be adequately and equitably met by increasing the Normal Retirement Age above those now scheduled (reaching age 67 in 2027). This would by no means be a deliberalization, but rather it would recognize that people would be in much better health by refraining from smoking. The result would then be to meet the desirable goal of "not only adding years to life, but adding life to years."

Attachment.

WORKSHOP

Life Expectancy at Age 30: Nonsmoking versus Smoking Men

By G. H. Miller, Charles E. Chittenden, and Robert J. Myers

Data derived from deaths in Erie County, Pennsylvania, reveal that the cost, in life expectancy, of a lifetime habit of smoking is dreadfully high—17.9 years.

IN MOST OF THE RESEARCH ON MEN'S SMOKING HABits reported over the last four or five decades, mortality rates were analyzed. While this approach is appropriate for comparing the impact of smoking on some smoking-related diseases, it does not provide a direct estimate of the difference in life expectancy as accurate as that derived from detailed life table analyses. To measure the full effect on smoking, the groups that should be compared are lifetime smokers and lifetime nonsmokers.

Lifetime smokers are defined here as those who have smoked all of their lives (from preteens, teens, or early adult years onward), with the possible exception of the last year of life. Nonsmokers include those who have smoked a maximum of twenty packs of cigarettes during their lifetime, or who may have been occasional cigar or pipe smokers.

The best known of the early prospective investigations on male cigarette smoking are the British Physicians study,[1] the American Cancer Society study,[2] and the U.S. Veterans studies.[3,4] Updates on these investigations have been included in every edition of the U.S. Surgeon General's reports on smoking and health.[5] However, except for one article by Hammond,[6] which cited an 8.3-year difference in life expectancy between male heavy smokers and male nonsmokers measured at age 35, the early reports dealt with comparative mortality rates.

In 1970 Preston[7,8] reported on mortality among adult males. He considered many theories, such as genetic, social, and physical explanations, as well as the possible

G.H. Miller is director of Studies on Smoking, Edinboro, Pennsylvania; Charles E. Chittenden is senior consultant with Alexander & Alexander Consulting Group, Atlanta, Georgia; and Robert J. Myers is former chief actuary, Social Security Administration, residing in Silver Spring, Maryland. *This article is based on a presentation made at the Annual Meeting of the Society of Actuaries, New Orleans, Louisiana, October 14, 1985.*

Constructing the Life Tables

The life table construction for Tables 2 and 3 uses the following definitions and formulas:

The central death rate, $M_{x,x+5}$, for the population from age x to $x + 5$ is given by

$$M_{x,x+5} = \frac{\textit{Adjusted Deaths}}{\textit{Population}}$$

where Adjusted Deaths are actual deaths, plus adjustment for nonrespondents.

The five-year survival rate ${}_{x+5}SR_x$, from age x to $x + 5$ is equal to:

$${}_{x+5}SR_x = (1 + M_{x,x+5})^5$$

Then quinquennial information is obtained for the life table based on these central death and survival rates.

The number of lives age x is obtained by setting the radix of the table (the number at the youngest age) equal to 100,000 and obtaining l_{x+5} from:

$$l_{x+5} = {}_{x+5}SR_x \times l_x$$

Then the number of years lived by the population from age x to $x + 5$, $T_x - T_{x+5}$, is obtained from:

$$T_x - T_{x+5} = \frac{l_x + l_{x+5}}{2} \times 5$$

The T_x column is obtained by summing the $T_x - T_{x+5}$ column, backwards, once the final value, T_{85}, is determined as follows:

$$T_{85} = \frac{l_{85}}{M_{85+}}$$

The expectations of life, e_x, are obtained from the formula:

$$e_x = \frac{T_x}{l_x}$$

Once again, the results of this approximation, when tested against the directly computed life table values (see Table B), show a small deviation (no more than 0.3% in any case).

BEST AVAILABLE COPY

effects of obesity, exercise, and stress. But he concluded that cigarette smoking was the major cause of the increased mortality among smoking men when compared with nonsmoking men.

In his reports, Preston also analyzed the difference in life expectancy between men and women. Once again, he implicated smoking as the major cause for the difference and provided extensive statistical support for this conclusion, derived from comparisons of male versus female smoking patterns. Preston noted "the dubiousness of the hypothesis linking mortality trends to genetic or social factors."[8] In another article,[9] he concluded that, "Rather than representing victimization by Nature or hostile social forces, the difficulties of older males appear to be largely self-imposed and avoidable." Preston's surmise that smoking was the principal reason behind the difference in longevity between men and women was corroborated by Retherford,[10,11] who analyzed smoking and the sex-related mortality difference, widowhood, and sex ratios.

Other investigators as well have discovered patterns in the difference in longevity of men versus women.[12-15] This discrepancy is not the focus of this article, but it is important to realize that much of the recent information on male smokers versus male nonsmokers derives from research into the differences in longevity of men and women.

Two recent U.S. retrospective studies compared male lifetime smokers with male lifetime nonsmokers. One was a Pennsylvania study alluded to before,[11] the other concerned New York state.[16] Previously, one of us (G.H.M.) reported a difference of 12 years in life expectancy between male lifetime smokers and male lifetime nonsmokers,[13] while Rose and Cohen[16] reported a 10-year difference. Both of these investigations made use of average-age-at-death statistics.

The gap in life expectancy between male smokers and nonsmokers was the subject of reports from the American Cancer Society[17] and the U.S. Veterans Administration.[18] The former reported a 6.98-year difference, the latter, a 9-year difference, between smoking and nonsmoking men. A 12-year difference was cited in a life insurance study completed by Cowell and Hirst.[19]

Because there is a potential bias in using average-age-at-death statistics, one of us (G.H.M.) recalculated the data from his 1976 report that compared lifetime smoking men with lifetime nonsmoking men by life table analysis. The life table analysis produced the same 12-year difference that was reported in the 1976 study,[13] and reiterated in 1986.[9] Then, to adjust for the potential bias arising from the nonrespondents in the study, the third author (R.J.M.) performed another recalculation of the data on lifetime smokers versus nonsmokers.

For both statistics and actuarial science, it is important to find out what kinds of differences might arise from using average-age-at-death statistics as opposed to life table analysis, with and without adjustment for nonrespondents. For this reason, the data from the survey of the smoking habits of the living population of Erie County, Pennsylvania, were used for this study. To our knowledge, this is the only one that considers a complete life table analysis, adjusted for nonrespondents, for comparing the overall life expectancy of lifetime male smokers with that of lifetime nonsmokers for a large percentage of a total population.

Methods and Procedures

The statistical method used in this study is the two-sample cross-sectional analysis introduced by Haenszel et al.[20] This technique combines data from a deceased population (numerator data) with data from a living population (denominator data). Compared with classic prospective studies, this method lets investigators derive mortality rates (and then life tables) rapidly. A weakness of this type of study, of course, is that it includes two sets of data, instead of one; this can mean less precise representations if special care is not taken to make the two population samples representative of the same population.

Using this technique, the lifetime smoking habits of adult men and women who died in Erie County, Pennsylvania, in 1972-74 (data derived from interviews with close relatives of the deceased) were incorporated with the lifetime survey data on the smoking habits of men and women who lived in Erie County in 1972-74 (data obtained by retrospective projection from a 1979 survey). Identical items were used in both surveys to assure the validity of the questionnaires. Telephone interviews were used, because results obtained this way seem to be more valid than those from questionnaires mailed to selected participants.[21]

Data on decedents' smoking habits carefully collected from close relatives and friends, it has been shown, are as valid as those obtained from the deceased prior to death.[22-25] In support of this conclusion, a recent analysis by one of us (G.H.M.) showed that the reporting of the deceased's cause of death by close relatives provided close approximations to the causes listed on death certificates (these findings are now being analyzed and prepared for publication). This analysis agrees with similar reports on retrospective studies, which demonstrate fairly close agreement in smoking classifications from surrogates and next-of-kin, and also supports the hypothesis that the number of cigarettes smoked, as detailed in other studies, is probably underreported.[26,27]

Study population. Erie, Pennsylvania, is a medium-sized city (the third largest in the state): its population in 1970 was 129,341, while that of Erie County was 263,654. Historically, the county has had a stable population, with an in-out migration of approximately 7% during the 20-year period, 1950-70. The people who live in Erie County are primarily middle-class Caucasians.

Data on the deceased population. In 1973 the Northwestern Pennsylvania Study on Smoking and Health (NPSSH) was begun to determine the smoking habits of the deceased residents of Erie County.[11] The data were collected via telephone interviews with relatives of the decedents.

Death notices for 1972-74 provided the names of nearly every person who died in Erie County in these years,

Data for this study are based on 1,879 males (699 present cigarette smokers; 394 former cigarette smokers who are not currently smokers, 241 present cigar or pipe smokers who are not currently cigarette smokers but may have been in the past; and 545 persons who never smoked cigarettes, cigars, or pipes).

Life Table Analysis

The overall estimated percentages of smoking men and nonsmoking men by age (in five-year cohorts) in the population of Erie County are listed in Table 1. Those who died during 1975-78 were not included in these estimates, since the data were not readily available. This loss, however, should have a negligible impact. Had these 1975-78 deaths been included, we would expect that the smokers' death rate would increase, since smokers have a higher mortality rate than nonsmokers.

Population statistics for the years 1972-74, provided by the Bureau of Vital Statistics of the Pennsylvania Department of Health, were combined with the percentage figures from the survey data of the living population to obtain the base person-years for smoking and nonsmoking men. The computations provided the denominators needed for the calculation of mortality rates in each five-year group.

Actuarial approximations had to be developed for the deaths that occurred within the period studied, since the information on deaths and populations exposed to risk was not available in the format that is normally used in mortality studies. (This procedure was also necessary in making the adjustment for nonrespondents.) When the adjusted number of deaths was divided by the number in the population exposed to risk, a one-year central death rate for the five-year age cohort was obtained.

One of us (R.J.M.) derived five-year survival rates for the exact age at the beginning of each five-year age group, in order to make a projection of the population from the beginning of the age group to its end. The proportion of the group surviving is given by the formula, the fifth power of the complement of the central death rate *M*, that is, $(1-M)^5$ (see footnote b in Tables 2 and 3).

The life table construction for Tables 2 and 3 uses the definitions and formulas shown in the adjacent box.

The deaths recorded in the NPSSH for the two categories, smoking and nonsmoking men, adjusted as described in the box, were used as the numerator data. The population and the reported deaths in each age category are shown in Table 2 for smokers, and for nonsmokers, in Table 3. These tables also display the adjusted deaths and death rates, the five-year survival rates and the survivors, and the computed life expectancy. The life table computations were made according to standard actuarial and demographic procedures,[28] using the adjustments for nonrespondents described in the accompanying box.

The Results

Table 1 gives broad, general support for the argument that those who quit smoking can expect great gains in survival.

Note also that, of those aged 85 and over, 47.4% were former smokers, while only 5.3% were smokers. The fact that so many of the men in this age group were former smokers explains why it is vital to isolate the data on former smokers from both the "nonsmoking" and "smoking" categories before attempting to make an accurate estimate of the mortality experience of lifetime smokers and nonsmokers.

Table 2 displays the life table analysis for male smokers in Erie County. Table 3 shows this analysis for nonsmokers. Table 4 compares the life expectancies for lifetime male smokers with those of lifetime male nonsmokers (for comparative purposes, life expectancies for all U.S. males, 1969-71, are included[29]).

The life expectancy of lifetime smokers was 17.9 years less than that of lifetime nonsmokers for males aged 30, after both traumatic deaths and nonrespondents were eliminated. These differences became smaller with increasing age. (Table 5 shows the original data reported to the Society of Actuaries at its 1985 meeting. The difference in life expectancy reported at that time was 12 years.)

Tables A and B represent tests for the approximation methods used to derive (1) the five-year survival rates and (2) the life table populations at ages x to $x + 4$, respectively, in Tables 2 and 3. These tests have, as a basis, the application of the stated approximations to a life table population and the comparison of the results with a direct computation of the elements involved, based on data for individual years of life. The results in Tables A and B show that the two approximations are satisfactory.

Discussion

Table 4 shows that, when the two-sample data from the deceased and living populations are transformed into life table data adjusted for nonrespondents, nonsmoking men at age 30 can, as a group, expect to enjoy 17.9 more years of life than their peers who smoke (excluding traumatic deaths). This present study, in which adjustments were made for nonrespondents, shows an increase of approximately 6 years in the difference in life expectancy of male smokers versus nonsmokers. This number is in agreement with the average-age-at-death estimates in the first report of the NPSSH and the life table analysis done six years later,[15] as well as the results of Preston,[7,8] Retherford,[10-12] Rose and Cohen,[16] Hammond,[17] and Cowell and Hirst.[14] However, to our knowledge, the 17.9-year difference cited here is the greatest difference reported to date.

Put another way, the data from the present study indicate that a 30-year-old man who smokes will reduce his life expectancy, on average, by about one-fourth. This result, too, is well within the experimental variations detailed in other studies. For example, mortality rates discussed in the comparison of smoking-related diseases in the U.S. Surgeon General's reports[4] show variations as high as 300% (male smokers versus nonsmokers).

Workshop, continued from page 33

Table 3

Life-Table Computations for Male Nonsmokers, Erie County, Pennsylvania, 1972-74

Age Group (x to $x+4$)	Population	Deaths	Adjusted Deaths[a]	Central Death Rate, M	5-year Survival Rate[b]	Survivors l_x	Population at Ages x to $x+4$ $T_x - T_{x+5}$[c]	Population Aged x and Over T_x[d]	Expectation of Life e_x
30-34	8,241	2	2.8	.0003	.9985	100,000	499,625	5,268,014	52.7
35-39	6,215	3	4.1	.0007	.9965	99,850	498,378	4,768,389	47.8
40-44	5,790	3	4.1	.0007	.9965	99,501	496,635	4,270,011	42.9
45-49	5,545	11	15.1	.0027	.9866	99,153	492,442	3,473,376	35.0
50-54	6,983	13	17.9	.0026	.9871	97,824	485,965	2,980,934	30.5
55-59	5,431	30	41.3	.0076	.9626	96,562	473,782	2,494,969	25.8
60-64	3,576	40	55.0	.0153	.9258	92,951	447,512	2,024,187	21.7
65-69	3,121	41	56.4	.0181	.9127	86,054	411,488	1,573,675	18.3
70-74	2,648	39	53.6	.0202	.9030	78,541	373,660	1,162,187	14.8
75-79	2,030	69	91.9	.0467	.7873	70,923	316,902	788,527	11.1
80-84	1,051	103	141.7	.1318	.4848	55,838	207,270	471,625	8.4
85+	1,048	78	107.3	.1024	—	27,070	—	264,355	9.8
Total	51,679	432	594.2	—	—	—	—	—	—

[a] Based on 72.7% of all deaths being reported in survey (telephone numbers obtained for 85% of descendents, telephone contact made in 90% of cases with telephone number available, and answers to inquiry in 95% of cases where contact made.)
[b] $(1 - M)$ to the 5th power—this is an accurate approximation (maximum error of 1.0%), see Table A
[c] $5/2\ (l_x + l_{x+5})$—this is an accurate approximation (maximum error of 0.3%), see Table B
[d] For $x = 85$, reciprocal of M times l_{85}. For other ages, by upward summation

Table 4

Comparison of Expectations of Life for Males

Age	U.S. Life Table for 1969-71	Erie County Nonsmokers	Erie County Smokers	Excess of Column (2) over Column (3): Amount	Excess of Column (2) over Column (3): Percent
30	40.5	52.7	34.8	17.9	51%
35	36.0	47.8	30.0	17.8	59
40	31.5	42.9	25.2	17.7	70
45	27.2	35.0	20.9	14.1	67
50	23.1	30.5	16.9	13.6	80
55	19.4	25.8	13.5	12.3	91
60	16.0	21.7	10.8	10.9	101
65	13.0	18.3	8.3	10.0	120
70	10.4	14.8	6.7	8.1	121
75	8.1	11.1	5.7	5.4	95
80	6.3	8.4*	4.3*	4.1*	95*
85	4.7	9.8*	2.7*	7.1*	262*

*These values particularly are not stable and are subject to substantial error, because of the small amounts of data on which they are based

Table 5

Life Expectancies of Adult Males by Age and Smoking Habits from a Two-Sample Cross-Sectional Population Study in Erie County, Pennsylvania, 1972–74*

Age	Deaths: Smokers	Deaths: Nonsmokers	Living Population: Smokers	Living Population: Nonsmokers	Life Expectancy: Smokers	Life Expectancy: Nonsmokers
30-34	7	2	9,816	8,241	38.4	50.9
35-39	7	3	8,977	6,215	33.5	46.0
40-44	40	3	8,970	5,790	28.6	41.0
45-49	73	11	9,299	5,545	24.2	36.1
50-54	129	13	8,632	6,983	20.0	31.5
55-59	205	30	7,508	5,341	16.4	26.7
60-64	252	40	6,664	3,576	13.5	22.4
65-69	234	41	3,664	3,121	10.7	18.6
70-74	181	39	2,004	2,648	8.9	14.6
75-79	133	69	1,330	2,030	7.7	10.6
80-84	74	103	526	1,051	6.1	7.1
85+	40	78	150	1,048	5.0	5.0
Total	1,375	432	67,540	51,589		

*Data reported at the annual conference of the Society of Actuaries, 1985

Table A

Test of Method of Approximating 5-Year Survival Rates Using U.S. Total Males Life Table for 1979-81

Age, x to $x+4$	$l_x - l_{x+5}$	$T_x - T_{x+5}$	Central Death Rate, M	Survival Rate from Age x to Age $x+5$: Computed From M	Survival Rate from Age x to Age $x+5$: Actual	Ratio
30-34	929	474,855	.00196	.9902	.9902	1.000
35-39	1,156	469,761	.00246	.9878	.9873	1.001
40-44	1,696	462,778	.00366	.9818	.9810	1.001
45-49	2,642	452,131	.00584	.9711	.9735	.998
50-54	4,071	435,505	.00935	.9540	.9543	1.000
55-59	5,924	410,703	.01442	.9299	.9303	1.000
60-64	8,366	375,225	.02230	.8934	.8941	.999
65-69	10,965	326,846	.03355	.8431	.8448	.998
70-74	13,409	265,648	.05048	.7718	.7753	.995
75-79	14,462	195,333	.07404	.6807	.6875	.990
80-84	13,790	123,781	.11141	.5540	.5665	.978
Total	77,410	3,992,566	—	—	—	—

Table B

Test of Method of Approximating Population at Ages x to $x+4$ Using U.S. Total Males Life Table for 1979-81

Age, x	5/2 X ($l_x + l_{x+5}$)	$T_x - T_{x+5}$	Ratio
30	474,828	474,855	1.000
35	469,615	469,761	1.000
40	462,845	462,778	1.000
45	451,640	452,131	.999
50	434,858	435,505	.999
55	409,870	410,703	.998
60	374,145	375,225	.997
65	325,818	326,846	.997
70	264,883	265,648	.997
75	195,205	195,333	.999
80	124,575	123,781	1.006

To some extent, these discrepancies in study findings result from differences in the way smokers and nonsmokers are classified. Some studies include former smokers in the "nonsmoking" category, while others place them in the "smoking" category.

However, adopting either of these classification systems would reduce the differences in estimated life expectancy between the smoking and nonsmoking categories. For example, the results in Table 1 show the inaccuracies that could arise in estimating life expectancy for lifetime smokers and nonsmokers if former smokers—who undoubtedly have greater life expectancies than smokers—are included in either the smoking or nonsmoking categories. It is also possible that prospective studies on the effects of smoking, now under way and expected to be completed in 30 to 40 years, will produce values similar to those reported here.

Some observers had suggested that adjusting the data for nonrespondents might decrease our previously reported life expectancy differential of 12 years (lifetime smokers versus lifetime nonsmokers)—but in fact, the opposite trend was observed. Since this is the only study in which adjustments were made for nonrespondents, it is possible that the other studies that did not do so may have also provided underestimates.

The final reports of prospective studies can be completed (and their results can achieve maximum accuracy) only when all the original participants in the study have died. Studies on smoking and health show that nonsmokers, as a group, live longer than smokers. This means that unfinished prospective studies will tend to yield underestimates of the mortality differences between smokers and nonsmokers. So the Rogot prospective study, which showed a 9 year difference in 1965, may well turn out to demonstrate a much higher difference when the final report on the project is completed in 2015. This difference may be as great as our life table estimate of 17.9 years. (This may hold true for other prospective studies as well.)

Continued research and future reports will determine which method provides the best estimate. But in any event, the obvious must not be overlooked—smoking is devastating to the health of the smoker. Concern for the public health requires an all out effort to curtail smoking. ☐

Acknowledgments

Support for this work was provided by a grant from the National Institute on Drug Abuse (contract no. 271-76-3311) to the Committee on Substance Abuse and Habitual Behavior, National Research Council, under the direction of Dean R. Gerstein, and by the Erie Chapter of the American Cancer Society, the Northwestern Pennsylvania Lung Association, and the American Heart Association of Erie County.

We wish to express our appreciation to Marvin A. Schneiderman, John A. Tust, and John P. Pierce for providing additional editorial comments to assist in the preparation of this article, and to Deborah Sullivan for assistance in the life table computations for earlier manuscripts.

References

1. Doll, R., and Hill, A.B. "Mortality in Relation to Smoking: Ten Years' Observations of British Doctors," [illegible] Report. British Medical Journal 1 (1964): 1451.

2. Hammond, E.C., and Horn, D. "Smoking and Death Rates—Report on 44 Months of Follow-up of 187,783 Men," JAMA 166 (1958): 1294.

3. Dorn, H.F. "Mortality of Smokers and Nonsmokers," in Proceedings of the Social Statistics Section of the American Statistical Association, December 27-30, 1958, p. 34.

4. Kahn, H.A. "The Dorn Study on Smoking and Mortality among U.S. Veterans: Report on 8 1/2 Years of Observation," in W. Haenszel, ed., Epidemiological Approaches to the Study of Cancer and Other Chronic Diseases. National Cancer Institute Monograph 19. Washington, DC: U.S. Government Printing Office, 1966, p. 1.

5. Reports of the Surgeon General (U.S. Department of Health, Education, and Welfare and U.S. Department of Health and Human Services), 1964 to present.

6. Hammond, E.C. "Smoking in Relation to the Death Rates of One Million Men and Women," in W. Haenszel, ed., Epidemiological Approaches to the Study of Cancer and Other Chronic Diseases. National Cancer Institute Monograph 19. Washington, DC: U.S. Government Printing Office, 1966, p. 127.

7. Preston, S.H. "The Age-Incidence of Death from Smoking," Journal of the American Health Statistics Association 65 (1970): 1125.

8. Preston, S.H. "An International Comparison of Excessive Adult Mortality," Population Studies 24 (1970): 5.

9. Preston, S.H. Older Male Mortality and Cigarette Smoking. Berkeley, California: University of California Press, 1970.

10. Retherford, R.D. "Tobacco Smoking and the Sex Mortality Differential," Demography 9 (1972): 203.

11. Retherford, R.D. "Cigarette Smoking and Widowhood in the United States," Population Studies 27 (1973): 193.

12. Retherford, R.D. "Tobacco Smoking and Sex Ratios in the United States," Social Biology 21 (1974): 193.

13. Miller, G.H. "Smoking and Longevity," Journal of Breathing (Illinois Lung Association) 39 (1976): 8.

14. Cowell, M.J., and Hirst, B.L. "Mortality of Smokers and Nonsmokers," Transactions of the Society of Actuaries 32 (1979): 185.

15. Miller, G.H., and Gerstein, D.R. "Life Expectancy of Nonsmoking Men and Women," Public Health Reports 98 (1983): 343.

16. Rose, C.L., and Cohen, M.L. "Relative Importance of Physical Activity for Longevity," Annals of the New York Academy of Sciences 301 (1977): 671.

17. Hammond, E.C., Garfinkel, L., and Lew, E.A. "Longevity, Selective Mortality, and Competitive Risks in Relation to Chemical Carcinogenesis," Environmental Research 16 (1978): 153.

18. Rogot, E., and Reid, D.D. "Smoking and Life Expectancy among U.S. Veterans," American Journal of Public Health 68 (1978): 1023.

19. Miller, G.H., Cowell, M.J., Above, R.E., et al. "Smoking and Sex Mortality Differences," Record—Society of Actuaries 11 (1986): 1877.

20. Haenszel, W., Loveland, D.B., and Sirken, M.G. "Lung Cancer Mortality as Related to Residence and Smoking Histories in White Males," Journal of the National Cancer Institute 28 (1962): 947.

21. Best, J.W. Research in Education, 4th ed. Englewood Cliffs, New Jersey: Prentice Hall, 1981.

22. Rogot, E., and Reid, D.D. "The Validity of Data from Next of Kin in Studies of Mortality among Migrants," International Journal of Epidemiology 4 (1975): 671.

23. McLaughlin, J.K., Dietz, M.S., Mehl, E.S., et al. "Reliability of Surrogate Information on Cigarette Smoking by Type of Informant," American Journal of Epidemiology 126 (1987): 144.

24. Hendricks, O.E., Jr., and Massey, J.T. "Trends in United States Telephone Coverage across Time and Subgroups," in Proceedings of the American Statistical Association Section on Survey Research Methods, 1978, p. 224.

25. Mookher, S.R., Khoury, J.C., and Madans, J.H. "Validity of Mortality Analysis Based on Retrospective Smoking Information," Statistics in Medicine (in press).

26. Kroll, L.A., Valadian, I., Dwyer, J.T., et al. "Accuracy of Recalled Smoking Data," American Journal of Public Health 79 (1989): 200.

27. Engeler, R.A., Pallonen, U.E., Murray, D.M., et al. "Validity of Telephone Surveys in Assessing Cigarette Smoking in Young Adults," American Journal of Public Health 79 (1989): 202.

28. Shryock, H.S., and Siegel, J.S. et al. Methods and Materials of Demography. Washington, DC: U.S. Government Printing Office, 1975.

29. U.S. Department of Health, Education, and Welfare, National Center for Health Statistics. U.S. Life Tables: 1969-71. DHEW Publication no. (HRA) 75-1150. Washington, DC: U.S. Government Printing Office, 1975.

BEST AVAILABLE COPY

PREPARED STATEMENT OF JOHN OATES

The fact is astounding, both in its simplicity and in its extent: **An estimated 390,000 Americans will needlessly die this year from the nation's most preventable cause of death, cigarette smoking.**

The American Cancer Society, American Heart Association, and American Lung Association, acting jointly as the Coalition on Smoking OR Health, commend the Senate Committee on Finance for convening this hearing on the health impact and costs of smoking. A plethora of scientific and economic analyses performed over the past three decades have confirmed that cigarette smoking has and continues to exact a tremendous toll on our society. Though the past decades witnessed many accomplishments, in terms of discouraging cigarette consumption, much more still must be done.

Our three organizations have devoted a great portion of our resources in our individual efforts to discourage cigarette smoking. Each one of our organizations has spent millions funding research, exploring the health impact of smoking as well as the health benefits of quitting. We have each funded and operated major educational/smoking cessation programs, which address all sectors of the population, from preschoolers to senior citizens; Blacks, Whites, Hispanics; the very wealthy as well as the very poor. We have developed public service announcements in an effort to further spread the word regarding the health benefits of quitting or not starting to smoke. And here in Washington, we have worked together pursuing legislative initiatives in furtherance of our health promotion/disease prevention mission.

Pursuant to the hearing announcement, our testimony focuses on the health impacts and financial costs of smoking. However, we believe that a discussion of potential solutions is just as important as a discussion of the underlying problem. The Coalition on Smoking OR Health has developed an extensive legislative agenda, which we believe, if enacted, would result in a significant decline in tobacco use. This would yield substantial health and financial benefits. Two specific agenda items, an increase in tobacco excise taxes and the elimination of the tax deduction for tobacco advertising expenses, are of particular relevance to the Finance Committee. A copy of our legislative agenda is appended.

HEALTH IMPACT

The 1989 Surgeon General's report, Reducing the Health Consequences of Smoking, estimated that each year 390,000 Americans die from smoking-related diseases. That averages to a daily death toll in excess of 1,000 lives, the equivalent of nearly three fully loaded jumbo jets crashing with no survivors every day. More than one in every six deaths in the United States is smoking-related. According to "Contingencies," the journal of the American Academy of Actuaries, "The data from the present research indicate that a 30-year-old man who smokes will reduce his life expectancy, on average, by about one-fourth."

Lung Cancer

The first Surgeon General's report on the relationship between smoking and health, published in 1964, concluded, "Cigarette smoking is causally related to lung cancer in men; the magnitude of the effect far outweighs all other factors. The data for women, though less extensive, point in the same direction." In the 25 years since that report, the causal connection between smoking and lung cancer, for both men and women, has been firmly established. Today, we know that cigarette smoking is responsible for 83% of all lung cancer cases and 30% of all cancer deaths.

Epidemiologic evidence now reveals a clear dose-response relationship between lung cancer risk and cigarettes smoked per day, degree of inhalation, and age at initiation of regular smoking. The most recent Surgeon General's report includes the following data:

* For those who smoked more that 40 cigarettes per day, the risk of dying of lung cancer was 23 times greater than the risk experienced by nonsmokers.

* Those who reported inhaling "none" or "slightly" experienced a risk of developing lung cancer that was eight times greater than that of nonsmokers. The relative risk increased to 17 for those who inhaled deeply.

* The risk of developing lung cancer was greatest for those who began smoking at an earlier age. Some studies suggest that duration of smoking, as contrasted to the number of cigarettes smoked, is the stronger determinant of lung cancer risk and that initiation of smoking during the teen-age years will have serious consequences for lung cancer risk.

With regard to women and lung cancer, 1986 was a landmark -- in the form of a tombstone -- year. For the first time, lung cancer surpassed breast cancer as the leading cancer killer among women. This statistic has led many of us to sadly note that indeed "you have come a long way, baby."

Because of their needlessness, all lung cancer deaths are lamentable. Yet, many of these victims at least will have had the option to choose whether or not to smoke. Now, we are becoming increasingly aware that a growing number of people will die of lung cancer, not because they have smoked, but because they have inhaled the cigarette smoke of others. The Surgeon General, the National Academy of Sciences, and the Environmental Protection Agency (EPA) have all estimated that thousands of Americans die yearly as the result of "passive smoking." The most recent data from EPA suggest that the risk of indoor air pollution from tobacco smoke is twice as great as the danger from radon.

Despite these sad facts, what remains amazing is the tremendous recuperative power of the human lungs once people stop smoking. One

study found that for both men and women who had smoked for less than 20 years and who had not smoked for 10 years, the risk of lung cancer declined to approximately that of a person who had never smoked.

Other Cancers

While cigarette smoking is the number one cause of lung cancer in the United States, it is also causally related to a number of other cancers. Epidemiologic evidence has confirmed that cancers of the larynx, oral cavity, and esophagus are directly related to cigarette smoking. As with lung cancer, a strong dose-response relationship has been established.

The 1989 Surgeon General's report noted the following cancer data:

* For bladder cancer, in both men and women, cigarette smokers have a relative risk of 2 to 3 times the risk of nonsmokers.

* There is a positive association between smoking and kidney cancer, with relative risks ranging from 1 to more than 5 times that of nonsmokers.

* Approximately 30 percent of pancreatic cancer mortality is attributable to cigarette smoking.

* Cancer of the stomach is associated with smoking.

* There is an increased risk for cervical cancer in cigarette smokers.

Coronary Heart Disease

Coronary heart disease holds the deadly distinction of being the number one cause of death in the United States. Every 32 seconds someone dies from cardiovascular disease. Nearly 67 million people, more than one in four Americans, suffer from some form of cardiovascular disease.

The 1964 Surgeon General's report noted that male cigarette smokers had higher rates of coronary heart disease than nonsmokers. Extensive clinical and statistical studies have since indicated that cigarette smoking is one of the major independent risk factors for heart attack. Smokers' risk of heart attack is more than twice that of nonsmokers. In fact cigarette smoking is the biggest risk factor for sudden cardiac death: smokers have two to four times the risk of nonsmokers. A smoker who has a heart attack is more likely to die suddenly (within an hour) than a nonsmoker.

Smoking is also the biggest risk factor for peripheral vascular disease (narrowing of blood vessels carrying blood to leg and arm muscles). In fact, this condition is almost exclusively confined to smokers. Smokers with peripheral vascular disease also are more likely to develop gangrene and require leg amputation. Benefits of corrective surgery are reduced when patients continue to smoke.

When people stop smoking, regardless of how long or how much they have smoked, their risk of heart disease rapidly declines. Ten years after quitting, the risk of death from heart disease for people who have smoked a pack a day or less is almost the same as for people who have never smoked.

Chronic Obstructive Lung Disease

Chronic obstructive lung disease (COLD) most commonly manifests itself as emphysema or chronic bronchitis. According to the 1984 Surgeon General's report on COLD: "Cigarette smoking is the major cause of chronic obstructive lung disease for both men and women. The contribution of cigarette smoking to chronic obstructive lung disease morbidity and mortality far outweighs all other factors."

The risk of developing COLD is 30 times greater among smokers than among nonsmokers. The Surgeon General has estimated that approximately 80 to 90 percent of COLD deaths are attributable to cigarette smoking. In 1984, more than 50,000 Americans died from smoking-related chronic obstructive lung disease.

Pregnancy and Infant Health

In recent years, attention has focussed on the impact of smoking on pregnancy. Studies have confirmed an association between maternal smoking and low birthweight babies, an increased incidence of prematurity, spontaneous abortions, stillbirths and neonatal deaths. Data contained within the most recent Surgeon General's report include:

* Cigarette smoking seems to be a more significant determinant of birthweight than the mother's pregnancy height, weight, payment status, or history of previous pregnancy outcome, or the infant's sex. The reduction in birthweight associated with maternal tobacco use seems to be a direct effect of smoking on fetal growth.

* Cigarette smoking and low hematocrit levels were two of the most important risk factors accounting for the differences in prematurity rates between Blacks and Whites.

* It was estimated that if all pregnant women stopped smoking, the number of fetal and infant deaths would be reduced by approximately 10 percent. In the United States, this would result in about 4,000 fewer infant deaths each year.

FINANCIAL IMPACT

No dollar value can be placed on the nearly 400,000 lives that are lost yearly as a result of cigarette smoking. Yet, we do know that our

country spends billions of dollars annually in treating smoking-related illnesses and that the economy loses billions more as the result of lost productivity.

The health care costs alone truly are astounding. The U.S. Department of Health and Human Services (DHHS) estimated earlier this year that cigarette smoking costs our nation $52 billion annually in health care costs. The annual per capita costs of smoking-related disease are $221 nationally. According to DHHS Secretary Louis Sullivan, "Cigarette smoking has an adverse economic impact on every American, whether or not he or she smokes. That $221 cost comes out of the pockets of smokers and nonsmokers alike, largely in the form of increased health-care and insurance costs."

A DHHS chart indicating smoking attributable economic costs by state is attached. The following data should be of particular importance to Members of the Senate Finance Committee:

State	Total Cost*	Per Capita Cost**
Arkansas	526.1	224
Colorado	603.8	189
Delaware	151.7	246
Idaho	142.2	143
Kansas	370.9	153
Maine	316.1	273
Michigan	2,110.4	233
Minnesota	877.0	209
Missouri	1,272.9	254
Montana	108.7	132
New Jersey	1,623.4	215
New York	4,611.8	260
Oklahoma	743.5	227
Oregon	433.7	161
Pennsylvania	2,926.3	247
Rhode Island	272.5	284
South Dakota	129.0	184
Texas	2,244.5	206
West Virginia	501.9	259

* In millions of dollars, 1985
** In dollars, 1985

Of course, health care costs are also borne by the federal government. A major analysis completed by the Office of Technology Assessment (OTA) in 1985 estimated that the federal government spent somewhere between $2.1 and $6.6 billion, or a middle estimate of $4.2 billion, in treating smoking-related illnesses through the Medicare and Medicaid programs as well as through some Department of Defense and Veterans Administration programs. Adjust these figures to account for FY 90 or FY 91 dollars and the smoking-related health care cost borne by the federal government may actually be higher.

(It should be noted that the 1985 OTA estimates were conservative. OTA only considered government program costs for persons aged 65 and older. The analysis did not take into account the fact that 75% of smoking-related health care costs are incurred by those under the age of 65.)

Beyond health care costs, the OTA also considered productivity losses borne by the economy as the result of smoking-related disease. For 1985, OTA estimated smoking-related productivity losses of between $27 and $61 billion, with a middle estimate of $43 billion. The middle estimate equates to about $1.45 for each pack of cigarettes sold.

In computing total smoking-related health care and lost productivity costs, OTA reached a middle estimate of $65 billion (1985 dollars), or $2.17 per pack of cigarettes.

The tobacco industry claims that tobacco contributes millions of dollars to the economy. The industry's self-serving analysis is fundamentally flawed. As University of Michigan economist Kenneth E. Warner has found, if tobacco were to disappear from the economy, the money and jobs currently devoted to tobacco would not disappear -- they would simply be redistributed to other products -- products which don't kill. Even the tobacco industry's own economists from Chase Econometrics acknowledge that the economy would lose virtually nothing if tobacco products were to disappear from the marketplace.

IMPACT ON YOUTH

Each year, nearly 400,000 Americans die from smoking-related illnesses. Another 1.5 million potential customers stop smoking or die from other causes. In order for the tobacco industry to maintain a market, it must replace these lost customers. It is for this reason that the tobacco industry has been targeting, more and more aggressively, women, minorities and youth. Today, the advertising, promotion and marketing practices of the tobacco industry constitute a health threat to the American public.

Last year the tobacco industry spent $3.25 billion to advertise and promote tobacco use. The industry maintains that their advertising efforts are directed only toward potential brand switchers. Yet, it is absurd to believe that promotional materials, like the Camel advertisement (see attached), done in cartoon format, which instructs hesitant coupon redeemers to call upon a friend or a "kind-looking stranger" to redeem a free pack of cigarettes for them, are aimed at anyone but underage youth.

Unfortunately, the industry's efforts are succeeding. Those children who begin to smoke are smoking their first cigarettes at even earlier ages. According to the most recent National Adolescent Student Health Survey, among 8th grade students who smoke, 13.8% of male smokers and 11.8% of female smokers smoked their first cigarette in grade 4 or below; 23.9% of male smokers and 24.3% of female smokers smoked their first cigarette in grade 5 or 6. Not surprisingly, given the addictive nature of tobacco products, 5.6% of male smokers and 10.8% of female

smokers reported they were smoking cigarettes on a daily basis by grade 7 or 8.

Purchases of cigarettes by children are made easy by many factors. First, in many locations, purchases may be made through unregulated vending machine sales. All a child must do is possess the requisite amount of change needed to make the vending machine respond. Insertion of a few coins into a machine provides the child with easy access to a substance, which is as addictive than heroin.

Second, the requisite amount of change needed to purchase cigarettes often is not much. Today, the average price of a pack of cigarettes in the United States is $1.50. In comparison, a McDonald's Big Mac costs $1.79, a non-matinee movie ticket costs $7.00, and a CD recording costs at least $10.00.

Of course, some children will make retail purchases of cigarettes. Here, too, the purchases are relatively easy. Few states seriously enforce minimum age of sales restrictions. Furthermore, the tobacco industry often circumvents minimum age restrictions by passing-out free samples at events attended by large numbers of teenagers.

POLICY IMPLICATIONS

The American Cancer Society, American Heart Association, and American Lung Association, acting jointly as the Coalition on Smoking OR Health, have developed a legislative agenda, the enactment of which, we believe, will yield a significant decrease in tobacco consumption. The Coalition's agenda is expansive including legislative proposals to: provide federal regulatory control over tobacco; restrict tobacco advertising; discourage international trade policies that require foreign countries to import American tobacco products; and discourage government subsidization of tobacco growth.

Two additional items on the Coalition's agenda are of particular relevance to the Senate Finance Committee. In an effort to discourage consumption, our organizations have long supported a substantial increase in the federal cigarette excise tax. Several legislative alternatives have been developed, including proposals to increase the tax by 16 cents, effectively doubling its rate, as well as proposals to increase the tax by 25 cents per pack. Our organizations have endorsed these proposals.

The primary basis for our support of a cigarette excise tax increase is the important health benefits that we believe will necessarily accrue. Cigarette smoking is inversely related to price, i.e., as price increases, demand decreases. As a result, an increase in the cigarette excise tax, when passed through to consumers, will encourage many people to quit smoking, and more importantly, will encourage many others not to start. A 1986 analysis by Michigan University economist Kenneth E. Warner, as well as a number of studies before and since, confirmed that "cigarette excise changes ultimately influence the health of smokers and nonsmokers."

More specifically, according to Warner, "a 16 cent increase in the excise tax would encourage almost 3.5 million Americans to forego smoking habits in which they would engage if the tax were to remain at 16 cents per pack. This figure includes more than 800,000 teenagers and almost 2 million young adults aged 20 to 35 years." Warner concluded that a doubling of the federal cigarette excise tax would diminish the teen-age smoking population by 17 percent.

The effect of an excise tax increase on tobacco use is well documented. In 1983, Congress enacted legislation increasing the federal cigarette excise tax from eight to sixteen cents. While the United States had regularly experienced declines in the incidence of smoking following the issuance of the first Surgeon General's report on smoking and health in 1964, the decline was never so precipitous as that which followed the doubling of the federal cigarette excise tax. Likewise, following the recent enactment of a 25 cent increase in its state cigarette excise tax, California has witnessed a substantial decline in cigarette purchases. (See attachments.)

Further proof may be found in the Canadian experience. Between 1980 and 1988 the cost of a pack of Canadian cigarettes tripled, due primarily to increases in federal and provincial taxes. In that same time period, tobacco sales fell 23 percent. Why? According to Jacques Lariviere, spokesperson for the Canadian Tobacco Manufacturers Council, "The single most important factor . . . has been the very dramatic increase in the retail selling price as a reflection of the equally dramatic increase in taxation."

The Coalition has also endorsed S.776, a proposal introduced by Senator Bradley, which would disallow deductions for advertising expenses for tobacco products. This proposal recognizes that the tobacco industry saves a billion dollars each year because its huge advertising and promotion budgets are tax deductible. Removing this privilege would substantially increase the cost of advertising and promotion and reduce tobacco manufacturers' financial incentive to spend so heavily. This proposal also relieves the American taxpayer of the burden of subsidizing the tobacco manufacturers' marketing efforts.

The 101st Congress of the United States has before it 30 years of experience and more than 50,000 studies, which have consistently confirmed that cigarette smoking is the leading cause of preventable death in the United States. Bi-partisan support exists within Congress for making cigarettes more expensive as well as more difficult to buy. The Administration has shown strong leadership in rejecting those tobacco marketing practices directed primarily at women, minorities and youth.

The Coalition on Smoking OR Health commends the Senate Committee on Finance for exploring the health and financial impact of smoking. But the time for exploration has long passed. Now is the time to act. We can no longer stand by and watch as our nation's children become addicted to the one product legally sold in our country that when used as intended kills. We urge the Senate Committee on Finance to endorse an increase in the federal cigarette excise tax as well as the elimination of the tax deduction for tobacco advertising expenses.

TABLE 6
SMOKING-ATTRIBUTABLE ECONOMIC COSTS BY STATE, UNITED STATES, 1985 IN MILLIONS OF DOLLARS

State	Direct Morbidity	Indirect Morbidity	Indirect Mortality	Pediatric Indirect Mortality	Total	Per Capita Cost*
Alabama	349.6	174.4	367.5	10.1	901.6	226
Alaska	34.7	16.4	28.8	2.4	82.3	165
Arizona	294.9	109.8	195.6	7.1	607.5	194
Arkansas	196.0	101.1	222.7	6.3	526.1	224
California	2,932.4	1,059.8	1,766.7	53.2	5,812.1	223
Colorado	329.3	109.8	157.3	7.3	603.8	189
Connecticut	348.7	123.6	222.2	6.9	701.4	222
Delaware	69.5	27.5	51.3	3.4	151.7	246
District of Columbia	19.0	26.0	82.0	3.0	130.0	211
Florida	835.2	407.4	790.1	28.1	2,060.7	183
Georgia	537.9	257.7	534.4	18.0	1,347.9	228
Hawaii	88.1	32.1	50.5	2.8	173.5	174
Idaho	68.6	25.6	46.8	1.3	142.2	143
Illinois	1,325.7	514.8	934.6	40.2	2,815.4	245
Indiana	563.9	448.1	231.4	14.4	1,257.9	229
Iowa	192.7	45.6	177.3	4.1	419.6	146
Kansas	159.4	70.3	136.4	4.9	370.9	153
Kentucky	327.0	170.0	397.5	12.3	906.9	246
Louisiana	263.8	138.4	302.9	8.8	713.9	160
Maine	124.7	57.0	128.4	6.0	316.1	273
Maryland	446.6	185.3	360.9	13.8	1,006.5	232
Massachusetts	847.5	288.4	462.0	21.2	1,619.1	279
Michigan	1,103.9	275.8	699.6	31.2	2,110.4	233
Minnesota	483.1	154.3	230.0	9.7	877.0	209
Mississippi	210.2	98.8	210.1	7.4	526.6	203
Missouri	594.7	232.0	434.6	11.5	1,272.9	254
Montana	39.9	20.6	46.3	1.8	108.7	132
Nebraska	156.4	56.3	91.8	3.0	307.6	193
Nevada	121.1	47.6	91.4	3.5	263.6	283
New Hampshire	95.0	40.4	81.6	1.8	218.9	220
New Jersey	701.7	301.1	604.2	16.3	1,623.4	215
New Mexico	71.9	33.1	62.4	4.6	172.0	120
New York	1,865.1	907.3	1,780.9	58.5	4,611.8	260
North Carolina	491.6	267.5	606.6	15.4	1,381.1	225
North Dakota	93.7	36.6	29.8	1.0	161.1	239
Ohio	1,246.2	481.7	885.5	24.0	2,637.4	246
Oklahoma	339.6	259.3	135.5	9.1	743.5	227
Oregon	151.6	83.5	192.3	6.3	433.7	161
Pennsylvania	1,403.7	542.4	954.6	25.7	2,926.3	247
Puerto Rico**	38.8	33.0	95.2	11.5	178.5	54
Rhode Island	133.0	48.7	90.0	1.0	272.5	284
South Carolina	227.9	124.3	282.0	8.4	642.5	196
South Dakota	60.7	24.2	42.0	2.0	129.0	184
Tennessee	284.4	352.6	157.2	11.7	806.0	170
Texas	1,618.9	617.0	1,079.2	29.4	3,344.5	206
Utah	43.2	27.0	18.1	3.8	92.1	56
Vermont	52.0	19.8	38.5	1.1	111.2	208
Virginia	534.4	236.0	455.7	16.9	1,243.0	224
Washington	428.7	153.0	281.2	14.3	877.1	202
West Virginia	199.1	93.2	206.2	3.4	501.9	259
Wisconsin	469.5	266.7	266.7	9.0	1,011.8	212
Wyoming	38.9	15.1	27.3	4.6	85.8	170
TOTAL	23,663.9	10,237.9	17,823.8	623.3	52,338.9	221
Highest State	2,932.4	1,059.8	1,780.9	58.5	5,812.1	284
Lowest State	19.0	15.1	18.1	0.8	82.3	54
AVERAGE	454.9	196.9	342.8	12.0	1,006.5	205

*in dollars, based on 1985 resident population estimates, U.S. Bureau of the Census
**based on 1983 data.

How to get a FREE pack even if you don't like to redeem coupons.

SMOOTH MOVE #437

1. Ask your best friend to redeem it.
2. Ask a kind-looking stranger to redeem it.
3. Ask a good-looking stranger to redeem it.
4. Offer each a Camel and start a warm, wonderful friendship.

SURGEON GENERAL'S WARNING: Cigarette Smoke Contains Carbon Monoxide.

LIGHTS 9 mg "tar", 0.7 mg nicotine, LIGHTS HARD PACK 10 mg "tar", 0.7 mg nicotine, LIGHTS 100's 12 mg "tar", 0.9 mg nicotine, FILTERS 16 mg "tar", 1.0 mg nicotine FILTERS HARD PACK 17 mg "tar", 1.1 mg nicotine, FILTERS 100's 18 mg "tar" 1.2 mg nicotine, REGULAR 21 mg "tar", 1.4 mg. nicotine, av per cigarette by FTC method

90704

MANUFACTURERS COUPON | EXPIRES 8/31/89

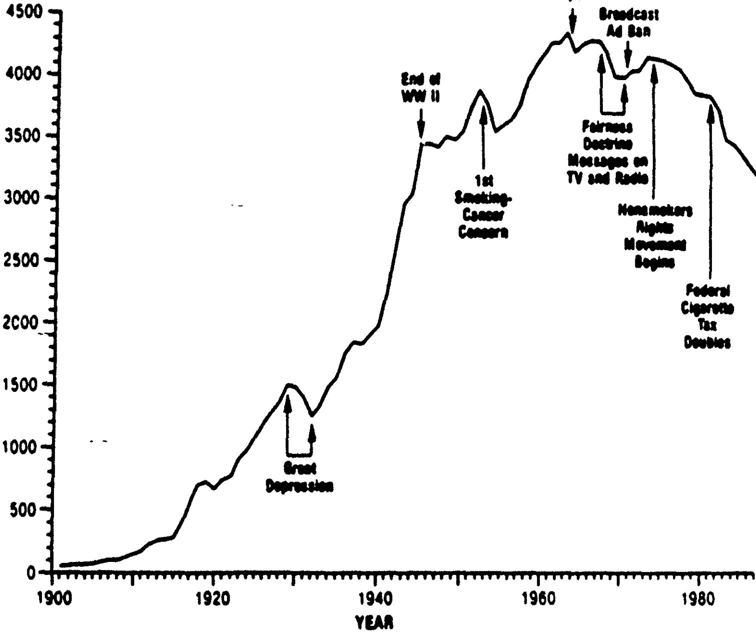
5 12300 10100 9

FREE Pack Of Camel!

When You Buy 1. Any Style.

RETAILER YOU MUST FILL IN NORMAL RETAIL PRICE ________ (DO NOT INCLUDE SALES TAXES)

90704



Reducing the Health Consequences of Smoking,

Report of The U.S. Surgeon General, 1989

35-777 O - 91 - 4

State Board of Equalization, Sacramento, California

CIGARETTE TAX REVENUES AND SALES* 1988 AND 1989

Period	Revenues			Sales (In packages of 20)		
	1988	1989	Percent Change	1988	1989	Percent Change
January	$ 17,569,282	$ 52,817,609	200.6	175,092,820	150,907,454	-14.1
February	19,097,212	52,514,221	175.0	190,972,120	150,040,631	-21.4
March	24,016,954	65,468,466	172.6	240,169,540	187,052,760	-22.1
First Quarter	$ 60,683,448	$ 170,800,296	181.5	606,234,480	488,000,845	-19.5
April	19,034,153	63,189,551	232.0	190,341,630	180,541,574	-5.1
May	23,482,207	67,209,806	186.2	234,822,070	192,028,017	-18.2
June	22,889,776	75,026,828	227.8	228,897,760	214,362,366	-6.4
Second Quarter	$ 65,406,136	$ 205,426,185	214.1	654,061,360	586,931,957	-10.3
January-June Totals	$ 126,089,584	$ 376,226,481	198.4	1,260,295,840	1,074,932,802	-14.7
July	18,493,824	NA	NA	184,938,240	171,835,504	-3.8
August	21,498,819	NA	NA	214,988,190	195,081,210	-9.3
September	21,805,014	NA	NA	218,050,140	NA	NA
Third Quarter	$ 61,797,657	NA	NA	617,976,570	NA	NA
October	20,730,498	NA	NA	207,304,080	NA	NA
November	21,606,493	NA	NA	216,064,930	NA	NA
December	23,623,951	NA	NA	236,238,510	NA	NA
Fourth Quarter	$ 65,960,942	NA	NA	659,609,420	NA	NA
July-December Totals	$ 127,758,599	NA	NA	1,277,586,090	NA	NA
Grand Totals	$ 253,848,183	NA	NA	2,538,481,830	NA	NA

* *Revenues include tax on cigarettes only.*
Sales are computed in packs of 20 based on number of individual cigarettes distributed.

BEST AVAILABLE COPY

Coalition on Smoking OR Health

1607 New Hampshire Avenue, N.W., Washington, D.C. 20009
(202) 234-9375

STEERING COMMITTEE
Scott D. Ballin, Chairman
American Heart Association
(202) [illegible]
Alan C. Davis
American Cancer Society
(202) [illegible]
Fran Du Melle
American Lung Association
(202) [illegible]

STAFF DIRECTOR
Matthew L. Myers
Asbill, Junkin, Myers & Buffone
ASSISTANT DIRECTOR
Clifford E. Douglas
Asbill, Junkin, Myers & Buffone

January 25, 1989

COALITION AGENDA FOR 1989-1990

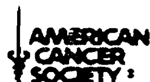
As a result of the progress of the 1980's, the effort to reduce the death and disease caused by tobacco use has reached a crossroads. To continue the progress of the past decade and to dramatically reduce smoking among our nation's youth, blue collar workers, minorities, women, members of the armed forces, and our nation's less well-educated will require determined, decisive public policy action.

The agenda proposed for 1989-1990 builds upon what has been accomplished and what has been learned over the last decade. The proposed agenda recognizes that public policy initiatives are only one part of what must be an overall comprehensive national effort, but that public policy initiatives must be major component of the comprehensive national effort, if it is to succeed. The proposed agenda also is based upon the principle that no one program or initiative will accomplish the task by itself. Public policy efforts must be combined with traditional public health strategies similar to those in which the American Heart Association, the American Cancer Society, and the American Lung Association have long been involved.

To succeed the following eight pronged blueprint must be considered together as an integral part of an overall coordinated effort, developed and implemented in tandem with traditional public health initiatives. These initiatives at the federal level also must be combined with state and local actions.

Finally, the proposed agenda recognizes that new and unforeseeable opportunities and challenges, such as the development of "Premier" by R.J. Reynolds, are likely to arise during the next two years as they have in the past and the coalition needs to be prepared to address them.

To this end, the following eight pronged agenda is proposed for the Coalition for 1989-1990:



A. ***Establishment of an Effective National Policy Which Prohibits the Sale or Distribution of Tobacco to Minors***

Tobacco products remain readily available to young people. In fact, there are fewer restrictions on children's access to tobacco products now than in 1964.[1] Tobacco products are easy for children to obtain because of the lack of regulations governing their sale and distribution, lax attitudes about enforcement, unrestricted free sampling, and the availability of tobacco products from unsupervised vending machines.

The following actions towards which the Coalition will work are a step in the right direction:

1. Enactment of a Federally Mandated Minimum Age for Tobacco Use: Congress has the authority to enact a federally mandated national minimum age for the use of tobacco products. In light of the fact that the establishment of a minimum age for tobacco use has traditionally been a state function, this legislation should place the primary enforcement responsibility at the state level, but should retain federal authority to establish minimum standards for those jurisdictions which do not do so on their own;

2. Enactment of a Nationwide Ban on Free Sampling: A prohibition on all free sampling of tobacco products will assist efforts to prevent the distribution of tobacco products to children; and

3. Enactment of a Ban on the Unsupervised Sale of Tobacco: Tobacco products currently are sold in unsupervised vending machines and in stores where the sales people themselves are too young to be able to smoke legally. Both activities contribute to the ease with which tobacco products are available to children. A prohibition on the sale of tobacco products except by or under the direct supervision of an individual old enough to legally purchase these products in order to prevent the unrestricted, unsupervised sale of tobacco products in vending machines will improve enforcement of minimum age laws.

---

[1] As of January 1, 1988, forty-two states and the District of Columbia restricted the sale of cigarettes to minors.

B. ***Restrictions on the Advertising and Marketing of Tobacco Products***

The tobacco industry spends close to $2.4 billion a year (or $6.5 million a day) marketing its products. The best available evidence indicates that these efforts do play a role in the decision of young people to smoke and may discourage current smokers from quitting. Tobacco industry marketing efforts also have been shown to have a substantial adverse effect on the media's coverage of the tobacco and health issue, the willingness of many organizations who normally take a leading role in protecting their constituents to speak out forcefully, and the atmosphere in which tobacco related health messages compete.

Therefore, decisive action must be taken to limit the corrosive influences of these practices, including:

1. Enactment of a prohibition on all tobacco advertising and promotional practices, including brand name sponsorship of events such as sporting events, rock concerts, jazz festivals;

2. Tombstone Advertising as an Alternative to a Total Advertising and Promotion Ban: If a complete ban on all tobacco advertising and promotional practices cannot be achieved promptly, three steps should be taken to eliminate the most serious abuses:

   a. a limit on all remaining tobacco advertising to tombstone advertising, such as:

      No human figure or facsimile thereof, and no picture other than the picture of a single package of the tobacco product being advertised displayed against a neutral background, shall be used in any tobacco product advertisement, provided that the product package displayed shall be no larger than the actual size of the product package and shall contain no human figure or facsimile thereof and no picture.

   b. a ban on advertising in sports stadiums and;

   c. a ban on brand name promotional practices, including brand name sponsorship (sponsorship of events by tobacco companies would be permitted as long as it was not done by or publicly associated with any brand or brands of tobacco products).

The tombstone approach permits the tobacco industry to continue to advertise using text-only advertisements thereby not restricting what they could say about their products in their advertisements, while eliminating the images which play such a powerful role with teens and younger children. Thus, the Tombstone approach is designed to eliminate those advertising practices of greatest concern. The tombstone advertising approach also would minimize any adverse economic effect on the media because advertising would still be permitted.

These actions to limit the impact of current tobacco industry advertising practices will be most effective if combined with educational efforts, such as the major federally funded program of anti-tobacco public service announcements described below. To the extent necessary, state and local authority to control and restrict purely local marketing efforts of the tobacco industry also should be clarified.

C. *Increased Educational Efforts*

Despite tremendous strides which have been made in the public's awareness that tobacco use is hazardous, substantial numbers of people do not know how dangerous tobacco is, whether the risks of tobacco use have personal relevance to themselves, whether they are among those groups, such as pregnant women, who are uniquely vulnerable to the health hazards of tobacco use, or whether tobacco is addictive.

Therefore, the Coalition will seek to enact legislation in three areas to address these problems directly. They are:

1. Legislation to mandate a major, federally funded, long term program of anti-tobacco public service announcements. The public service announcements of the late 1960's contributed significantly to the large decline in tobacco use in the late 1960's and virtually all experts agree that a major program of anti-tobacco public service announcements offers one of the most effective opportunities for countering the billions of dollars spent by the tobacco industry to promote its products and for providing the public with a more complete understanding of the hazards of tobacco use;

2. Legislation to Require an Addiction Warning: All tobacco packages and advertisements and promotional material should contain an explicit warning: "Tobacco Is Addictive: Once You Start You May Not Be Able To Stop."

3. <u>Legislation to Require the Inclusion of Tobacco in All Health Education Curriculum</u>: The health hazards of tobacco use should be part of the standard health curriculum in all schools, and education about the health hazards of tobacco should be included in all drug education programs in the schools.

4. <u>Increased Funding for the Office on Smoking And Health within the Centers for Disease Control</u>: The budget of the Office on Smoking and Health has grown little over the past decade and should be increased to at least $5 million annually.

D. ***Federal Regulation of Tobacco Products***

Tobacco products are exempt from virtually all federal health and safety regulations. Thus, the federal government currently cannot do anything about the fact that 43 separate, known carcinogens have been identified in tobacco smoke, cannot prevent tobacco manufacturers from adding additional chemicals known to be harmful to tobacco products, cannot restrict how much nicotine--a highly toxic, addictive substance--tobacco manufacturers add to their products, and cannot control what is added to the filters appended to tobacco products despite the knowledge that for a number of years asbestos was added to the highly popular Kent Micronite Filter. There is even question at present whether the federal government can regulate new alternative nicotine delivery systems, such as "Premier", as long as manufacturers put some tobacco somewhere in the product.

No other consumer product is exempted from as many laws and regulations designed to protect the American public. To protect consumers, tobacco should be treated the same as other consumer products. Therefore, legislation is necessary to remove the special status accorded to tobacco and this legislation at a minimum should include:

1. <u>Regulation Of Tobacco Products by the Food and Drug Administration</u>: Legislation should provide explicit authority to the Food and Drug Administration to regulate tobacco products. The FDA should be authorized, among other things, to:

   a. Require that all additives and chemicals used in tobacco products be shown to be safe;

b. Regulate the introduction of, claims made about, and the advertising for all nicotine containing products, whether or not they contain tobacco,

c. Oversee the regulations prohibiting the sale and distribution of tobacco products to minors,

d. Require the disclosure of tar, nicotine, carbon monoxide, and other harmful constituent levels in cigarettes,

e. Require the disclosure of the ingredients used in each brand of cigarettes, and

f. Regulate the advertising and marketing of tobacco products, as it currently does for prescription and non-prescription drugs to eliminate practices which encourage consumption or create false impressions about the product's safety.

E. ***Federal Tax Policy***

Despite the fact that an increase in the excise tax on tobacco products has been proven to be one of the most effective mechanisms for discouraging teenagers from starting to smoke, the federal excise tax on cigarettes has been increased just one time in the last 37 years and is lower today in constant dollars than it was in 1951. Even when state and federal excise taxes on tobacco products are combined, they are lower today in constant dollars than they were before the release of the 1964 Surgeon General's report, a situation which is poor health policy and which has cost the government billions of dollars in revenue.

The federal government also has been losing close to a billion dollars a year in tax revenue by permitting the tobacco companies to deduct as a legitimate business expense the full cost of their advertising and promotion efforts. The American taxpayer should not be subsidizing the tobacco industry's marketing efforts by providing it with this tax deduction.

Tax policy does influence whether people smoke and the ability of the tobacco industry to attract new smokers. Those who argue that tax policy should be developed without regard to public policy considerations ignore the reality of what occurs whether or not the tobacco excise tax is increased. If the federal government does nothing, its current policies will have the effect of assisting the tobacco industry to continue to

promote its product. Only by acting, can the federal government bring its tax policy into line with sound health policy.

Therefore, the Coalition will work for the following:

1. <u>An Increase in the Excise Tax on All Tobacco Products</u>: An increase in the federal excise tax on cigarettes of no less than 16 cents, and preferably more, and comparable increases in the excise tax on other tobacco products. States and local governments should also consider comparable increases in their taxes on tobacco products.

2. <u>The Elimination of the Tax Deduction for Tobacco Marketing Expenses</u>: The tax deduction that tobacco companies currently receive for tobacco related advertising and promotional expenditures should be eliminated.

F. ***Protection of Nonsmokers***

The 1986 Report of the Surgeon General thoroughly documents the health hazards posed by involuntary smoking and the evidence of the hazards of involuntary tobacco smoking continues to mount. As a result, the majority of states and hundreds of communities have enacted protections for nonsmokers, and Congress has enacted a two-year ban on smoking aboard all domestic commercial flights of two hours or less.

More needs to be done at the federal level, however, including:

1. <u>Extension of the Ban on Smoking on Commercial Aircraft</u>: The ban on smoking aboard commercial aircraft on flights scheduled for two hours or less expires in April 1990. It should be made permanent and should be extended to all flights over which the federal government has authority.

2. <u>Ban on Smoking on Interstate Buses and Trains</u>: A ban on smoking on interstate buses and trains where nonsmokers cannot be provided with separate smokefree cars should be enacted.

3. <u>Protections for Nonsmokers in Federal Buildings</u>: The current regulations restricting smoking in many federal government buildings should be extended to all federal government buildings and other public facilities over which the federal government has authority.

H. ***Foreign Trade Policy***

Even while the federal government publishes new studies which document the health hazards of tobacco use, it has been aggressively promoting the export of tobacco to Japan, South Korea, Thailand, and Third World nations and has been exercising its trade leverage with these nations to open their doors to American tobacco products. The authority of the United States should not be used to promote the use of a product which is this nation's number one preventable cause of premature death and disease in Third World nations. This is a problem which can be solved without the enactment of new legislation if the Executive Branch alters its trade priorities. Therefore,

1. Modification of Trade Policy Priorities: The federal government should adopt a trade policy consistent with its health policy and hereinafter cease using its trade leverage to promote the export of tobacco, particularly to Third World nations and the Coalition will work within the Executive Branch to encourage the Trade Representative and the Department of Commerce to adopt such a policy;

2. Enactment of a Requirement that a Health Warning be Placed On Exported Tobacco Products: American tobacco exporters should be required to place health warnings on all packages of tobacco exported from the United States. If the nation to which the products are exported does not have its own health warning requirements, then those packages should contain the health warnings currently required on tobacco products sold in the United States, but they should appear in the language of the importing country. If an importing nation already has its own health warning requirements, the requirements of the importing nation should apply.

G. ***Domestic Agricultural Policy***

Despite the enactment of the No Net Cost Tobacco Act of 1982 the federal government continues to spend substantial sums of money to support the growth of tobacco. According to the Department of Agriculture, as the result of legislation enacted in 1986, the tobacco price support program cost the federal government $159.7 million in 1986; in 1987 the figure rose to $279.2.

The federal government should not financially promote the growth of tobacco and should assist tobacco farmers willing to

stop growing tobacco. Therefore, the Coalition will work to enact the following legislation:

1. <u>The Elimination of Federal Financial Support for the Growth of Tobacco</u>: No federal expenditures should be permitted to pay for, administer or otherwise support the tobacco price support program and no federal funds should be pledged to guarantee tobacco loans or the sale of tobacco for export;

2. <u>Federal Financial Assistance for Farmers Who Wish to Stop Growing Tobacco</u>: A federally funded program should be created (perhaps using the federal excise tax on tobacco products) to provide financial assistance to tobacco farmers who are willing voluntarily to stop growing tobacco. Tobacco allotments owned by farmers who participate in the program would be retired, thereby decreasing the overall number of tobacco allotments and the total acreage devoted to the growth of tobacco.

1989AG

PREPARED STATEMENT OF LOUIS W. SULLIVAN

Mr. Chairman and Members of the Committee: Thank you for the opportunity to testify at today's hearing. I congratulate you for your efforts to focus attention on the issue of tobacco and health. Given the tremendous toll that tobacco addiction wreaks on our nation's health, and especially on the people served by programs under your jurisdiction, it is urgent that we work vigorously together to develop strategies to curtail use of this addicting substance. This hearing is especially timely because May 31st is "World No-Tobacco Day." This event, which is sponsored by the World Health organization, is much like the Great American Smoke-out. The theme of World No-Tobacco Day this year is Smoking and Children.

Today I will summarize the scope and nature of the problem of tobacco addiction in the United States, particularly as it affects our nation's children and youth. I also want to discuss some of the steps my Department is taking to reduce the use of tobacco.

THE HEALTH CONSEQUENCES OF SMOKING

We have made tremendous progress toward our ultimate goal of a smoke-free society since the first Surgeon General's report on smoking and health in 1964. A quarter century ago, 40 percent of adults—and more than half of all men—smoked cigarettes. Today fewer than 30 percent of adults smoke, and almost half of all living Americans who ever smoked have quit. Per capita cigarette consumption has fallen each year since 1973.

Nonetheless, cigarette smoking remains the single, most important preventable cause of death in our society. Smoking is directly responsible for about 390,000 deaths each year in the United States; thus, we can fairly blame smoking for more than one of every six deaths in our country. It is astonishing to realize that the number of Americans who die each year from diseases caused by smoking exceeds the number of Americans who died in all of World War II, and this toll, unfortunately, is repeated year after year after year.

I am particularly concerned about smoking among pregnant women, and among our children and teen-agers. Women took up smoking in large numbers in the 1940s and 1950s. Since that time, the rate of smoking has declined much more slowly among women than among men. Cigarette companies have aggressively targeted women since 1928, when women were asked to "Reach for a Lucky Instead of a Sweet." A more contemporary advertising campaign associates smoking with women's liberation—"You've Come a Long Way, Baby."

However, these ads fail to point out that smoking is an equal opportunity killer. Lung cancer has overtaken breast cancer as the number one cause of cancer death among women, and lung cancer death rates among women continue to increase at an unrelenting pace. Other smoking-related diseases, such as heart disease, and emphysema, also are exacting a terrible toll on women in this country. For example, a recent article published in the New England Journal of Medicine showed that women who smoke are more than three times as likely to have a heart attack as women who have never smoked. This study and hundreds of others have demonstrated that women who smoke like men are going to die like men who smoke. Smoking is one area where women are unfortunately outdoing men in one respect; at present, young women are more likely to smoke than young men.

Women who are addicted to tobacco are obviously affecting their own health, and that is unfortunate enough. But women who smoke during pregnancy are undeniably affecting their own babies. Women who smoke during pregnancy are more likely to have miscarriages, and they are more likely to have dangerously small babies, or babies who die during their infancy. To put it in very plain terms, being born too small is a hazard to your health, and too many of our babies are suffering this hazard as the result of women smoking during pregnancy. The danger of smoking during pregnancy is real—smoking doubles the risk that a baby will die—and it is pervasive—there are around 900,000 infants born each year to smoking mothers. We know that smoking increases a woman's chances of having an underweight baby. Anyone who has held an underweight baby in their arms, as I have, realizes what a tragedy it is to have a child begin its life way behind the "starting line." It is all the more tragic, when smoking is the cause, because smoking is avoidable.

These tragedies have a financial and budgetary impact as well. Neonatal intensive care for low birth-weight babies costs about $3 billion a year. We estimate that about one-fourth of all low birth-weight babies are attributable to smoking during pregnancy. Thus, elimination of all smoking by pregnant women could save up to $750 million nationally, and the savings to the Medicaid program are estimated to be between $150-200 million.

With these kinds of statistics, it is clear that elimination of smoking among childbearing women would greatly reduce infant mortality and many other health problems and their associated costs. My Department conducts a number of programs which are trying to develop educational methods that can be used to reduce smoking among pregnant women. For example, through the "Smoking Cessation in Pregnancy" (SCIP) project, the Centers for Disease Control is providing assistance to states to develop and integrate smoking cessation information into public prenatal services. If the development of these educational methods is successful, then they can be applied more broadly.

Smoking among young people is a special concern of mine that I want to highlight today. Here's an area where we have had some good news. Smoking among high school seniors actually declined between 1976 and 1980 from 29 percent to 21 percent, but has leveled off since 1980. The really disheartening news is that some one million teens start smoking each year; this amounts to about 3,000 each day, and many of these go on to become addicted for life. In fact, about 90 percent of adult smokers began their addiction as children or adolescents, so the conclusion is clear: these young smokers account for almost all of our future problems. We know that the younger a person is when he or she starts to smoke, the more likely he is to become a long-term smoker and to develop smoking-related diseases. Preventing youngsters from taking up smoking is far more cost-effective than treating addiction later in life, and far less expensive than treating the resulting diseases.

As long as a significant proportion of teens view smoking as a desirable, adult pleasure, and become addicted before they can make a mature judgment, we will never succeed in achieving a smoke-free society. It is all too apparent that we, as parents, as educators, as health officials, and legislators, still do not take the problem of smoking among our children and adolescents as seriously as we should. We allow, for example, a constant barrage of cigarette advertising that portrays smoking as safe, sexy, and sophisticated, themes which appeal strongly to impressionable adolescents. And we have found it convenient to look the other way as cigarettes are openly sold to our nation's youth.

As with so many other health issues, tobacco addiction should be attacked with prevention measures, and this means that we should mount a vigorous effort to discourage our children and youth from ever starting to smoke. With this in mind, I want to present to you today a new initiative, one which I believe has the potential to make a great contribution towards smoking reduction among youth.

IMPROVED ENFORCEMENT OF STATE LAWS AGAINST SMOKING BY MINORS

In March I asked the Office of the Inspector General (OIG) of HHS to assess the enforcement of state laws prohibiting the sale of cigarettes to minors. I also asked my staff to explore techniques which states could adopt to improve the enforcement of these laws.

I am releasing the OIG report today. I would like to summarize it and introduce a copy of the report into the record. Its findings confirm both the findings of other studies and what we already suspected from every day observation. The findings boil down to this simple and unacceptable fact: our children can easily buy cigarettes virtually anytime they want to in violation of the law. Clearly, something has to change!

The OIG collected information in three ways. First, law enforcement and public health officials were contacted in every state to obtain data on enforcement activity and the views of these officials regarding enforcement of these laws. Second, the OIG identified and obtained information on unique, aggressive, and effective state or local enforcement efforts. Third, the OIG interviewed 1200 law enforcement officials, public health officials, educators, youth, parents, and vendors in 18 states and over 300 communities to assess their knowledge of enforcement.

Let me now provide the highlights of this report:

- Forty-four states and the District of Columbia have laws which make it an offense for retailers to sell cigarettes to minors. However, these laws are being blatantly ignored.
- Of the 44 states with such laws, only five could even tell our investigators how many violations had been identified either at the state or municipal level. These five states found a total of 32 violations in 1989, and the remaining states simply didn't know. Thus, nationally we can document 32 violations of the sales laws, while we know that almost one billion packs of cigarettes are illegally sold to our youngsters each year. This is truly a national disgrace.
- Two-thirds of the state public health officials reported that there was virtually no enforcement of their state law, and most of the rest said enforcement was minimal.
- Because most youth access laws are criminal statutes, only the police can enforce them. Law enforcement officials said that other enforcement priorities and a reluctance to take such cases into crowded court systems dampened their enthusiasm to enforce these laws.
- Over 80 percent of both students and adults interviewed by the OIG reported that it is easy for youth to buy cigarettes. Over 60 percent of vendors agreed

As you can see, the overall enforcement record is abysmal. The OIG, however, did find tiny pockets of active enforcement, mostly local communities with strong and enforceable laws.

- The OIG identified eleven jurisdictions where officials have made serious attempts to end the sale of cigarettes to minors. These communities are the state of Florida; Leominster and Brookline, Massachusetts; Woodridge, Illinois, Allentown Pennsylvania; Minneapolis and White Bear County, Minnesota; Layton, Utah; King County (Seattle), Washington; Marquette County, Michigan; and Solano County, California.
- The jurisdictions that the OIG identified are successfully enforcing their laws and have offered recommendations for even better performance. The enforcement tools which seem effective in these communities include licensing of tobacco vendors and revocation of licenses for violations, civil rather than criminal penalties for violators, use of "stings" to identify illegal sales, posting of signs at points of sale, and bans or restrictions on vending machines.
- Above all, these communities have found that leadership by government officials accompanied by local support and commitment are vital

In sum, where state and local officials take their responsibilities seriously, and devise enforcement tools which are workable and effective, these laws can be successfully enforced. The job can be done! In just these few communities, it is likely that tens of thousands of youth will avoid addiction and extend their healthy lives. What other public health initiative can promise such results at such low cost?

I also asked my staff to use the experience of successful—and not so successful—enforcement efforts to develop a model law which states could adopt. Today, I am releasing the "Model Sale of Tobacco Products to Minors Control Act," and I recommend that every state in the union consider legislation along these lines. I hope that the Nation's governors, all of whom are certainly interested in practical preventive health measures, will get behind legislation to attach this critical problem. We will be working with the leadership of the National Governors Association and other groups to assure that the model bill is considered in each and every state.

I would like to summarize the proposed legislation and introduce a copy of it into the record. The proposed model law has several key features, which would do the following:

- Create a licensing system, similar to that used to control the sale of alcoholic beverages; thus, a store could sell tobacco to adults only if it avoids selling to minors. Signs stating that sales to minors are illegal would be required at all points of sale.
- Set forth a graduated schedule of penalties—monetary fines and license suspensions—for illegal sales so that store owners and employees face punishment propor-

tional to their violation of the law. Penalties are fixed and credible. Those who comply need pay only an annual license fee.

• Provide separate penalties for failure to post a sign, and higher penalties for sales without a license.

• Place primary responsibility for investigation and enforcement in a designated state agency, such as the State Health Department, but allow local law enforcement and public health officials to investigate compliance and present evidence to the state agency or file complaints in local courts.

• Rely primarily on civil penalties to avoid the time delays and costs of the court system, but allow use of local courts to assess fines, similar to traffic enforcement. This provides flexibility to both state and local authorities to target enforcement resources

• Ban the use of vending machines to dispense cigarettes; this provision reflects the difficulty of preventing illegal sales from these machines. You can't buy beer from a vending machine, why should you be able to purchase cigarettes there? In recognition of the economic impact of such a ban on vending machine owners, states may wish to consider a phased approach leading to a complete ban.

• Contain a number of features to minimize burdens on retail outlets: require identification only for those who are not clearly above the age set by the state, allow a driver's license as proof of age, set a nominal penalty for the first violation, disregard one accidental violation if effective controls are in place, have the state provide required signs, and set license fees lower for outlets with small sales volume.

I would add that our emphasis on civil money penalties in this model legislation reflects the success that my Department has had using this new tool, that was developed legislatively by the Finance Committee. The use of civil penalties has been particularly successful in addressing Medicare fraud.

In summary, the model law attempts to create workable procedures which will provide retail outlets the incentive and tools to refuse to sell tobacco to minors, as already required by law in 44 states. Stores which comply will have no burden other than a licensing fee and, in some cases, replacement of vending machine by over-the-counter sales. Compliance by responsible stores, which would quickly become the great majority, will enable state and local authorities to concentrate enforcement efforts on a small number of recalcitrant outlets. The few stores which are unable or unwilling to prevent tobacco sales to minors may elect to stop carrying tobacco products, or will lose the license to sell them. Adult smokers would be unaffected by the proposed law.

Ultimately, the effectiveness of state laws depends on the willingness of concerned citizens to report violations to authorities who are responsible for investigations and enforcement. We are sure that enough citizens are concerned; the model law should help state legislatures develop an effective and efficient system to handle their complaints. However, we feel that merely putting an effective enforcement mechanism in place is the single most important reform The better the mechanism, the less likely it will have to be used.

I would like to add that if some states are unable to put this proposal into place then cities and counties can certainly do so. The OIG study clearly showed that local jurisdictions can have a noticeable impact on cigarette sales to minors if they choose.

Regardless of the level, I urge the adoption of legislation based on this model bill. No state or city could take a more effective health-enhancing action for its citizens than enactment of a set of well-designed enforcement tools aimed at eliminating the sale of cigarettes to minors. Businesses, which are struggling with the costs of providing employee health benefits, should recognize the long-term value of this bill, as it should diminish the number of people who get hooked on smoking while young—only to become disease victims later.

Mr. Chairman, this proposal represents only one of the initiatives we are taking; you are well aware of my abiding concern for the impact smoking is having on minorities. I look forward to working with you and other members of Congress to promote a tobacco free lifestyle. Elimination of this addictive substance will do more to enhance the length and quality of life in the United States than any other step we could take. Unlike many of the issues which this Committee examines each year, moreover, smoking reduction can be achieved at very low cost to Federal or state budgets. Indeed, smoking reduction creates positive fiscal effects on employment and income tax revenues, and on both public and private retirement funds and medical insurance, due to prolongation of working years and reduced illness during those years.

Attachments.

YOUTH ACCESS TO CIGARETTES

Richard P. Kusserow
INSPECTOR GENERAL

MAY 1990

INTRODUCTION

PURPOSE

To assess the enforcement of State laws prohibiting the sale of cigarettes to minors.

BACKGROUND

As part of his initiative on smoking, Secretary Sullivan asked the Office of Inspector General to survey States regarding their laws on the sale of cigarettes to minors. He specifically wanted to know the extent to which the laws are enforced, the nature of enforcement activities and the most effective practices. Although the Surgeon General reports that most States have youth access laws, there is little information on their enforcement.

Research has documented that children smoke. Each day more than 3,000 children start smoking. A Journal of the American Medical Association article estimates that more than 3 million American children under age 18 consume 947 million packs of cigarettes yearly. Additionally, 75 percent of current adult smokers started smoking before their 18th birthday. The Annual High School Seniors Survey, conducted in 1987 by the University of Michigan, reports that approximately one out of every five high school seniors smoke daily, and that over half the seniors who smoked began smoking by the eighth grade.

According to a study by the Minnesota Tobacco-Free Youth Project, the earlier a child starts using tobacco, the more likely it is that he/she will be unable to quit. The same study found that more than one-half of high school seniors who smoke daily have tried to quit without success.

States have responded to the fact that children smoke by passing laws that prohibit the sale of cigarettes to minors. Currently, 44 States and the District of Columbia have such laws. The age at which children are no longer considered minors ranges from 15 to 19, with 18 being the most common. These are not new laws; most were enacted between 1890 and 1920 as a result of pressure from activists who were trying to prevent young boys from smoking. As recently as 1964, 48 States had laws prohibiting the sale of cigarettes to minors, but some were repealed because they were considered unenforceable. In at least 11 States vendors must post signs stating it is illegal to sell cigarettes to minors.

Penalties for violation of these laws vary greatly -- from a $2 fine in Washington D.C., to a maximum of a $3,000 fine and/or a year in jail in Minnesota. In most States the penalty is a fine and/or jail. Despite the fact that virtually all States license the sale or distribution of cigarettes, only four have license revocation as a penalty for selling to minors. Most States leave enforcement to local law enforcement officials. However, in Florida and New Hampshire, State taxation agencies have the responsibility; in Massachusetts, it is the State Department of Public Health.

Indications that enforcement may be weak came not only from the observable fact that teens are smoking, but also from a number of studies and from controlled purchases or "stings" that demonstrated children can and do buy cigarettes. Dozens of such local "stings" have been run by researchers, local reporters, police, and health departments to test youth access laws. Generally, minors were able to purchase cigarettes illegally about 80 percent of the time.

Additionally, in 1987, nearly 90 percent of a sample of Minnesota 10th graders who smoked regularly reported that it was *very easy* to obtain cigarettes despite a State law. In the 1987 "National Adolescent Student Health Survey" of 1100 students, 73 percent of the 8th and 10th graders said it was very easy to buy; 13 percent said its fairly easy. Also in 1987, 90 percent of a sample of New Jersey high school students who smoked said they could *always* or *nearly always* buy cigarettes.

METHODOLOGY

Data collection was performed in three stages. Initially, the study team interviewed each State health and law enforcement agency where access laws exist to document enforcement activity. Interviews were conducted with a person designated in each State as the tobacco contact person in response to a request from the Association of State and Territorial Health Officials. This tobacco contact person described his/her awareness of enforcement activities as well as perceived problems with enforcement. The law enforcement official contacted was the State-designated National Crime Information Center (NCIC) contact, who was asked to provide statistics on the enforcement of these State statutes.

In the second stage of the inspection the team studied specific State and local enforcement efforts. An extensive literature review and contact with State officials, experts and academics in the youth smoking field indicated 10 local areas and one State, Florida, where enforcement was actively occurring. Individual communities actively enforcing youth access laws are located in California, Illinois, Massachusetts, Michigan, Minnesota, New York, Pennsylvania, Utah and Washington. In-person and telephone interviews, using open-ended discussion guides, were utilized to study these special enforcement efforts.

In the third stage, OIG staff assessed the public's knowledge and awareness of laws prohibiting the sale of cigarettes to minors. A questionnaire was developed, and almost 1200 interviews in urban and suburban settings were completed during April. The interviews took place in over 300 communities in eighteen States: California, Connecticut, Colorado, Georgia, Illinois, Kansas, Maryland, Massachusetts, Missouri, New Jersey, New York, Ohio, Pennsylvania, Texas, Vermont, Virginia, Washington and Wisconsin. The subjects interviewed included 295 vendors, 322 students and 561 other adults. These adults included 112 school officials, 95 law enforcement officials, 87 public health officials and 250 parents. The number of respondents varies by each question.

FINDINGS

Youth Access Laws Are Not Being Enforced, and Children Can Easily Buy Cigarettes.

State officials report that laws are not being enforced.

Two-thirds of State health department officials indicate that there is virtually no enforcement of their State law; another fifth say it is minimal.

Nearly half of the State health officials believe the law is not being enforced because it is not a priority. "People don't get excited about tobacco," explained one health official. The general sentiment is captured in another official's response that "people feel [that] there are more important issues that must be enforced." Other State health officials cite both a lack of funding and difficulty in enforcing the law as reasons for nonenforcement.

State-level police data also confirm the minimal level of enforcement. The majority of NCIC control agencies contacted could not provide actual numbers on violations and enforcement. Of the 44 States with laws prohibiting the sale of cigarettes to minors, only five could provide any statistical information on vendor violations:

STATE	1989 VENDOR VIOLATIONS
Alaska	8
Connecticut	0
Florida	16
New York	8
Vermont	0

A notable area of statistical accomplishment is Utah which in 1989 issued 4476 violations to minors for purchasing and/or possessing tobacco.

Law enforcement officials in the remaining States report that municipalities are either not required to report such minor offenses, or that all such offenses are lumped together in a miscellaneous category and cannot be accessed separately.

Discussions with local law enforcement officials further confirm the impression that little is being done. More than three-quarters interviewed from 78 communities around the country do not think youth access laws are being enforced in their communities. In fact, 76 of 39 (85%) report that they do not know of anyone ever being caught breaking this law.

Local public health officials agree. More than two-thirds interviewed believe the law is not being enforced in their local area; 64 of 73 respondents (88%) do not know of anyone ever being caught under this law.

Community respondents also note lack of enforcement.

More than three-quarters of respondents in the community also say youth access laws are not being enforced. This includes 246 of 320 student respondents (77%) and 429 of 559 adults (77%) including law enforcement officials. Half of the vendors surveyed agree.

Respondents in the community also do not know anyone who has ever been caught selling cigarettes to minors; 206 of 255 student respondents (81%) and 421 of 488 adult respondents (86%) do not know anyone who has ever been caught. The majority of vendors, 227 of 268 (85%), are likewise unaware of anyone ever being caught.

Respondents also say children can easily buy cigarettes in their community. The majority of adult and student respondents, 477 of 560 adults (84%) and 269 of 319 students (84%), consider it easy. Of 159 children who say they have smoked, 139 (87%) claim that it is easy to buy cigarettes. About two-thirds of the vendors agree.

Despite easy access and lack of enforcement, most respondents are, nevertheless, aware of the youth access law in their State. Three-quarters of students know of these laws. Similarly, 479 of 552 responding adults (86%), including 90 of 94 law enforcement officials (96%), are aware of them. Most store clerks, managers and owners, 266 of 292 (91%), know it is illegal to sell cigarettes to minors. When asked how they became aware of these laws, vendors most often mentioned that it is common knowledge, while others report that their employer informed them.

Lack of enforcement is due to apathy.

Overall, both adults and vendors suggest apathy as the major reason why these laws are not being enforced. Of the 429 adult respondents who believe the law is not enforced, 97 (23%) believe that the law is not a priority with the police or limited resources for enforcement exist. Ninety-five (22%) say the law is not a community priority and no one really cares about it. Ninety-three (22%) blame vendors for not caring who they sell to and just wanting the profits from sales. Only 17 adult respondents (4%) blame a lack of awareness of the law.

Vendors generally agree with adult respondents. Of the 145 vendor respondents who believe the law is not enforced, 30 (21%) say that vendors in general do not care who they sell to and find it inconvenient to check identification. Thirty (21%) believe that the police are too busy to enforce the law and 28 (19%) suggest public apathy.

Other respondents in the community attribute nonenforcement to, as one respondent noted, "a lack of political pressure to have police or anyone else enforce it." Others believe that teens would get cigarettes anyway, especially from vending machines, and that the law is too difficult to enforce.

The majority of experts in the youth smoking field and officials in the communities taking local initiative believe these laws are a low police priority. "The police don't acknowledge it as a problem," one respondent explained. As one local official noted, "Local cops have more than they can handle. They don't have time for this law." One expert commented that "enforcement is not occurring because the community is not making a fuss about it." Others cite a lack of leadership and the absence of an identifiable person or agency responsible for enforcement.

The majority of the law enforcement officials confirm that it is not a priority and say they have more important issues to address. As one officer notes, "The law is not important enough to have officers using their time to enforce it." Local law enforcement agencies also mention reluctance to take these cases into the congested court systems, noting that prosecution of criminal laws is not only time consuming but costly.

Areas of Active Enforcement Are Few; They Rely on Local Leadership.

Local leadership exists in nearly all active enforcement areas.

Eleven active enforcement initiatives were identified and contacted; all but one (Florida) were local initiatives supported by the community. These areas include:

Solano County, CA
Brookline, MA
Marquette County, MI
White Bear Lake, MN
Layton, UT
Woodridge, IL
Leominster, MA
Minneapolis, MN
Allentown, PA
King County, WA

In eight of these areas, local laws have been established and are being enforced, while in the remaining three the State law is being enforced.

In some States, these active communities have served as examples for other municipalities which have now also adopted similar enforcement policies. There may be more than one active town in each area; however, interviews were held only with those who first became active.

Generally, these enforcement initiatives have resulted from community concern and local leadership. In Woodridge, a local junior high school principal became concerned when a young student was seen purchasing cigarettes in a nearby store, and asked the youth officer from the local police department if it was illegal. After some research, the officer discovered it was, in fact, illegal. The officer then helped write a town ordinance prohibiting sale to minors and possession by minors. In the last year, three vendors' licenses have been suspended and over 30 minors have been ticketed. Many surrounding towns followed his lead and adopted similar local ordinances.

In Massachusetts, in response to an apparent lack of enforcement of the youth access law, the State Health Department asked local health departments to take on the responsibility. So far, two have accepted and are issuing tickets to violators. Both towns have adopted the State law as a local public health law, thus allowing enforcement by local health inspectors.

Information obtained at a smoking conference showing that nine percent of seventh graders smoke motivated the Allentown Health Department to look into enforcement of the State's law. In its first test of the law, it found that all 15 of its 15 test stores sold cigarettes to minors.

In Solano County California, the Cancer Control Program, concerned about the public health effect of teens smoking, encouraged three local police departments to enforce the State's law. These efforts resulted in 31 arrests.

Active Enforcement Involves a Variety of Techniques, Primarily Administrative in Nature.

Among the most commonly used techniques are licensing, fines, stings, restrictions on vending machines, and warning signs.

Licensing appears to be an effective tool in enforcing youth access laws.

Of the eleven active programs contacted, eight provide for revocation or suspension of the vendor's license following a prescribed number of violations. While all States license the production, distribution or sale of tobacco, only 31 license vendors; the remaining States license the wholesaler or the distributor. The source of these licenses varies; some are issued locally and others are issued by the State. Suspending a vendor's right to sell cigarettes for a period of time has greater impact than a fine, according to active enforcers. Since sales can account for hundreds of dollars of a store's daily intake, a minor monetary fine, in contrast, is relatively painless to pay. Also, a vendor who is forced to turn customers away may lose customers. Officials in these communities agree that a license revocation penalty causes vendors to obey the law. They point to the virtually self-enforcing alcohol laws as models.

Three types of license revocation were identified in the active communities. In Florida, the law prohibiting the sale of tobacco to minors is enforced by the Division of Alcoholic Beverages and Tobacco. Vendors who violate cigarette access laws can and do have their license to sell alcohol suspended. This occurred 16 times last year. In Brookline and Leominster, where the law is enforced by the local health department, vendors lose their food licenses. The first license was suspended recently. In the remaining sites, tobacco licenses issued locally to vendors are revoked when misused. In all three cases, suspensions are for a period of days for the first offense and longer for each added offense. One active enforcer stressed the importance of making these punishments reasonable. "If you make it too severe, you'll lose that crucial community support."

License fees vary greatly and can be used in many ways. Fees charged for these vendor licenses range from $5 for 3 years in Marquette County, MI to $210 for 3 years in King County, WA. In some areas (King County and Florida) fees are earmarked to pay for enforcement, while in others (Brookline) they fund tobacco and health education programs.

Civil fines work better than criminal penalties.

While criminal offenses must work their way through the criminal justice system, civil offenses are generally handled administratively. Seen as a viable alternative in the enforcement of youth access laws, they are used in six of the eleven active communities. Civil penalties expedite enforcement through the use of non-traditional enforcement officials (i.e., health inspectors, licensing inspectors, etc.), and avoid needlessly clogging the criminal justice system. In Minnesota, the penalty for selling to a minor is a gross misdemeanor, which if enforced, could mean jail for the clerks who sell. However, when three clerks in Ramsey were arrested for selling to minors, there was a public outcry for more lenient penalties. Minneapolis thus chose to punish violators civilly, going after the owner's license rather than the clerk.

In Florida, the access laws are criminal and violators must appear in court. Criminal court judges, however, feel strongly that these violators should not be burdened with a criminal record for such a common offense. The judges issue fines, but the violators are not adjudicated as guilty and, therefore, avoid criminal records. In some California criminal courts, judges have suspended sentences and have only issued fines. They also believe that criminal penalties do not fit this crime.

In Leominster and Brookline, sanitarians and public health officials issue tickets on which the fines are outlined. Cases are handled entirely by the health department; the police are not involved.

Overall, civil penalties are well received by active communities. When asked why other State youth access laws are generally not enforced, a majority of active community respondents believe it is because it is not a police priority; some blame public apathy. They feel that people, while not wanting children to purchase cigarettes, believe that police should be concentrating on more important issues, like illegal drugs and rape.

Police involved in actively enforcing these laws believe that the laws should be civil as opposed to criminal and would be more appropriately enforced by health departments and licensing officials. One of the more successful police enforcers stated, "The police department should not enforce this law. Citizens would argue there's not enough manpower. The health department is a more appropriate arm because it is not an offensive crime. It is a health issue - an administrative issue."

Stings are most often recommended as an enforcement technique by active communities.

A sting is conducted under the supervision of an enforcing agency which attempts to have a teenager purchase cigarettes from a vendor. All but two of the active localities use stings. In some cases, teenagers are paid by the agency running the sting and are considered special agents. Recruited from schools, advocacy programs, or police cadet programs, they are chosen because they look young and are warned not to lie about their age if asked, to avoid charges of entrapment. In some areas of Florida, the children are taken before a judge prior to the sting to assure that they look underage. In some communities, like Woodridge, a plainclothes officer enters the store before the child and pretends to be shopping so the purchase can be witnessed. Although the Woodridge law does not require that the officer witness the sale, police feel it adds to the validity of the charges. Woodridge estimates that quarterly stings of all 34 of its local tobacco vendors can be completed in just 4 hours by one officer. In addition to running quarterly stings, Woodridge also follows up on complaints from the community with additional stings.

Several active communities noted that stings by researchers and activists eventually led to community involvement. In California, the Solano County Cancer Prevention Program conducted the initial stings to see if there was a problem, not to catch violators. This led to stings by police with violators being punished. Likewise, in Woodridge, DePaul University researchers performed several stings to alert the town council to the existence of the problem, which led to the creation of the local ordinance.

When asked for suggestions as to how youth access laws could be enforced, the use of stings was the answer given repeatedly, with one respondent stating that, "Stings are vital to enforcement." Additionally, active enforcers generally believe that stings should be done regularly as opposed to being done only in response to a complaint. Another active enforcer said, "Stings are the only way to enforce. Complaints are not enough; no one complains. There is no alternative to stings."

The accessibility of vending machines is addressed when designing successful youth access laws.

Vending machines are estimated by a National Automatic Merchandising Association study to account for 16 percent of illegal cigarette sales to minors, and the younger children are, the more likely they are to purchase from a machine. Enforcement experts agree that effective youth access legislation should deal with vending machines. Currently, 51 percent of State health department officials report that they have no policy concerning vending machines, and another 33 percent say they merely require a warning sign to be posted on the machine. In contrast, seven of the eleven active communities deal with vending machines with total bans, locking devices or limited placement requirements.

Limited placement allows for vending machines in places that do not normally allow children anyway (i.e., bars, offices or factories). Currently, only 6 percent of State health departments interviewed report that their youth access laws limit the placement of vending machines, but half suggest limiting placement.

Locking devices require the installation of a relatively inexpensive device that inactivates the machine until a clerk triggers the power, thus allowing the clerk to check the age of the purchaser. Utah experimented with locking devices recently with limited success. Reportedly, clerks would simply activate the machine without checking the age of the purchaser. Since locking devices require employee participation, they are often not as effective in busy places, such as bars or restaurants, where employees are more likely to simply activate the machine.

Sixteen municipalities in Minnesota recently banned cigarette vending machines entirely. These bans have generally been well received and are expected to lead to stricter enforcement of over-the-counter sales. The remaining 42 percent of State health department officials say that total bans are the only way to prevent teens from using vending machines.

Warning signs remind both clerks and customers that sale to minors is illegal.

Currently, seven of the eleven active communities require vendors to post signs at the point of sale stating that it is illegal to sell to minors. Similarly, 55 percent of State health departments say vendors in their States are required to post warning signs. In Massachusetts, vendors must place these signs in such a way that they face the clerk as a constant reminder. In Utah, innovative designs and neon colors have been used to make signs distributed by local health departments more noticeable. In addition to signs, Woodridge clerks wear buttons reminding customers of the new ordinance. While enforcement experts stress that signs alone are not enough to stop illegal sales, they are a constant reminder to both children and employees.

Experts believe that making tobacco laws similar to alcohol laws would be an effective enforcement mechanism.

Enforcement in Florida, conducted by the Division of Alcoholic Beverages and Tobacco, is the same for alcohol and tobacco sales to minors, although ages differ (21 and 18, respectively). Three other States with similar alcohol/tobacco control agencies are not actively enforcing tobacco access laws, although they have the authority. At least two alcohol control agencies (ME, WA) report that their State legislatures are considering authorizing them to enforce existing tobacco access laws. Sixty percent of State health department respondents believe that the alcohol enforcement model would work for tobacco, and point to the license revocation provision in particular. Those who feel that the alcohol enforcement model would not work for cigarettes cite the extremely high number of tobacco vendors, which far exceeds the number of alcohol vendors.

Those proposing new youth access legislation are cautioned not to preempt any already existing local activity.

Officials in charge of active enforcement initiatives based on locally enacted ordinances caution that State laws should not preempt stronger local legislation. As a case in point, California recently passed a State law which precludes municipalities from enacting tobacco control laws.

Opinions vary as to whether or not to make it illegal for minors to possess cigarettes.

In five of the eleven sites contacted, it is illegal for a child to possess cigarettes. Enforcement experts believe this makes enforcement easier, serves as an additional deterrent and gives the vendor leverage when refusing to sell to minors. Penalties for youth violators range from 5 hours of community service to a $50 fine. In two areas enforcement is directed at the minor as opposed to the vendor: ticketing teens and suspending them from school and extra-curricular activities for possessing cigarettes is central to Utah's approach; White Bear Lake, MN brings them to the police station when caught in possession of cigarettes. California notes that caution must be used when performing stings in communities where possession or purchase is illegal. These minors must either be police agents or have special police permission.

MODEL SALE OF TOBACCO PRODUCTS TO MINORS CONTROL ACT

**A Model Law Recommended for Adoption
by States or Localities
to Prevent the Sale of Tobacco Products to Minors**

**U.S. Department of Health and Human Services
May 24, 1990**

Introduction

The great majority of states prohibit sale of tobacco products to minors. Yet over one million teenagers start smoking each year, and minors buy about one billion packs of cigarettes each year. Because nicotine is an addicting drug, a minor who starts smoking is likely to be a lifelong customer--and one in four will die prematurely of lung cancer or other smoking-related disease. Illegal tobacco sales dwarf illegal alcohol and hard drug sales to minors, and the resulting mortality is many times greater--390,000 deaths a year. These are preventable deaths, and many of them occur because youth can obtain tobacco products with ease. Over eighty percent of teenagers correctly believe that it is very easy for them to buy cigarettes.

Access of minors to tobacco is a major problem in every state of the nation. About three-fourths of the million outlets which sell cigarettes to adults also sell cigarettes to minors. These stores ignore the laws of their states because enforcement is almost non-existent. Many retailers are even unaware that such sales are illegal. Yet there are straightforward enforcement approaches which can eliminate almost all sales to minors while yielding revenues to cover the cost of enforcement. Teenage smoking can be greatly reduced without disruption either to governments or to sales to adults.

Data on the nature and extent of the enforcement problem, and information on successful community efforts to prevent illegal sale of tobacco products to youth, are presented in the report of the Office of the Inspector General titled "Youth Access to Cigarettes," dated May, 1990. Additional information on this issue can be obtained from the Office on Smoking and Health, within the Centers for Disease Control of the Public Health Service.

The Department of Health and Human Services has reviewed options for improving enforcement. The approach we have developed is embodied in a draft model law. We recommend that each of the 50 states enact this model. No state now uses all of the tools needed to make enforcement effective. In states which are not immediately willing to adopt the model law, counties and cities can enact most features by ordinance and prevent children's access to tobacco products.

No enforcement scheme is perfect. Many of those who are already addicted will find ways to get tobacco to meet their craving for nicotine. But for most teenagers, easy access to tobacco products and addiction can be eliminated. For others, reductions in frequency and numbers of cigarettes smoked will decrease the likelihood of becoming long-term smokers.

Summary of the Model Law

The model law has several key features. These are summarized below and discussed further in the section-by-section analysis. Some of these features can and should be modified by each state to reflect its internal organization and processes. But the underlying approaches, however implemented, are key to effective enforcement. The model law would:

o Create a licensing system, similar to that which is used to control the sale of alcoholic beverages, under which a store may sell tobacco to adults only if it avoids making sales to minors. Signs stating that sales to minors are illegal would

be required at all points of sale.

o Set forth a graduated schedule of penalties--monetary fines and license suspensions--for illegal sales so that owners and employees face punishment proportionate to their violation of the law. Penalties would be fixed and credible. Those who comply would pay only a license fee.

o Provide separate penalties for failure to post a sign, and higher penalties for sales without a license.

o Place primary responsibility for investigation and enforcement in a designated state agency, and exclusive authority for license suspension and revocation in that agency, but allow local law enforcement and public health officials to investigate compliance and present evidence to the state agency or file complaints in local courts.

o Rely primarily on state-administered civil penalties to avoid the time delays and costs of the court system, but allow use of local courts to assess fines, similar to traffic enforcement. This would provide flexibility to both state and local authorities to target enforcement resources. (An illegal sale could not result in two fines, but a local conviction would be reported to the state and count towards possible license suspension).

o Set the age of legal purchase at 19. This is higher than under many existing state tobacco statutes, but lower than the age for alcohol. States may wish to consider age 21, because addiction often begins at ages 19 and 20, but rarely thereafter.

o Ban the use of vending machines to dispense cigarettes, parallel to alcohol practice and reflecting the difficulty of preventing illegal sales from these machines. (This is another area where states should examine options carefully; allowing sales in places not legally open to minors, or use of store-controlled electronic enabling devices, may be acceptable alternatives. States could also consider phasing of the ban to minimize disruption.)

o Contain a number of features to minimize burdens on retail outlets: requiring identification only for those who are not clearly above the age of 21, allowing a driver's license as proof of age, setting a nominal penalty for the first violation, disregarding one accidental violation if effective controls are in place, having the state provide required signs, and setting license fees lower for outlets with small sales volume.

The model law does not explicitly address several topics, including possession of tobacco by minors, earmarking revenues for enforcement, allowing local ordinances to be stronger than the state law, and authorizing use of minors in "sting" operations to detect violations. This does not mean that states should not consider including such provisions, as discussed further below, but that we did not believe them necessary or appropriate within the statute. For example, use of stings will be vital to effective enforcement of this law, but like other investigative procedures need not be detailed in statute.

In summary, the model law attempts to create workable procedures which will provide retail outlets the incentive and tools to refuse to sell to minors, as already required by law in almost all states. Stores which comply will have no burden other than a licensing fee and, in some cases, replacement of vending machine by over-the-counter sales. Compliance by responsible stores, which would quickly become the great majority, will enable state and local authorities to concentrate enforcement efforts on a small number of recalcitrant outlets. The few stores which are unable or unwilling to prevent sales to minors may elect to stop carrying tobacco products, or will lose the license to sell tobacco products. Adults will continue to be able to buy cigarettes and other tobacco products at a wide range of outlets.

Ultimately, the effectiveness of this legislation depends on the willingness of concerned citizens to report violations to authorities who are responsible for taking investigatory and, if necessary, enforcement action. We are sure that enough citizens are concerned; the model law simply provides an effective and efficient system to handle their complaints, filling voids in almost all state enforcement schemes. Indeed, merely putting an effective enforcement mechanism in place is the single most important reform. The better the mechanism, the less likely it will have to be used.

Section-by-Section Analysis

Section 1 states the title of the bill, here suggested as "Sale of Tobacco Products to Minors Control Act."

Section 2 presents appropriate findings of fact. Most important, in this context, are that tobacco products are addicting, that addiction almost always starts in teenage years, and that smoking causes death on a large scale. States exploring these issues may wish to consult recent reports of the Surgeon General, which summarize and synthesize the large body of knowledge extant.

Section 3 establishes a state "Office of Tobacco Control" and the key powers of that office. Whether that office would best be located in the Department of Health or the state alcohol sales licensing agency, or established as an independent agency, is uniquely a matter for state-specific decision.

Two key provisions of section 3 require the Office to operate a licensing system and to prepare and distribute to licensed outlets signs concerning sales to minors. Requiring a license for sale of tobacco products conditions the privilege of sale on compliance with the law. Later in the bill heavy penalties are provided for any sales (or free distribution) to any persons without such a license. Failure of licensed outlets to prevent sale to minors leads to financial penalties and revocation of the license. The text is worded to allow licensing mobile vendors--it is not the purpose of the law to harm any small businesses.

The state agency is empowered to investigate and enforce the law. The investigative and enforcement techniques are not specified in detail, since these are generally routine and well-established administrative functions. However, the most powerful technique for both investigation and enforcement will in most circumstances involve testing compliance

by sending underage persons to stores which sell tobacco products--especially those have been reported for illegal sales. A request to purchase cigarettes is then made and the sale, if consummated, provides evidence of violation of the statute. Properly designed and supervised by state or local officials, such testing can readily and inexpensively establish whether an outlet violates the law, and provide the basis for a formal complaint and enforcement decision. States and communities now using this approach often hire teenagers to perform this function as temporary employees, to provide insurance protection to the teenagers and assure proper supervision. Depending on other law (e.g., whether possession by minors is illegal) and court rulings, some states may wish to authorize this approach explicitly. Tennessee does so now.

The model law provides that local officials may also investigate violations, and either assist the state agency by bringing evidence before it or bring cases directly in local courts. Local officials in some cities and counties will have the resources and expertise to contribute significantly to enforcement. Such contributions will not only speed enforcement directly, but allow the state agency to allocate its resources where they are most needed. In general, the assumption of the bill is that there will be substantial state and local cooperation, similar to the kinds of arrangements used for traffic violations. A varied local role in investigation and enforcement will also be useful in identifying techniques which are particularly effective within each state.

The license fee is suggested as $300 for most stores but only $50 for stores with a volume of tobacco sales below $5,000 a year. This should provide enough revenue to make enforcement budget-neutral, while protecting small businesses from what might be perceived as an onerous cost in relation to sales. Of course, enforcement costs will not necessarily vary by size of outlet and a state could balance these considerations differently. Regardless, a state could use additional distinctions (e.g., by size, or whether licensed to sell alcoholic beverages) or set these fees higher or lower; depending on other licensing systems, its revenue goals, and whether it wishes the tobacco control system to be fully financed through license fees. We have not suggested earmarking revenues to accrue directly to the Tobacco Control agency rather than the general fund, but some states might wish to do this.

Section 4 requires license holders to display the license and sign (section 7 provides a monetary penalty for failure to display them). A visible sign provides continuing notice to all --sales clerks, underage customers, and older customers--as to the law's requirements and the store's declared willingness to comply. The sign also aids clerks in refusing to sell to underage customers.

Section 5 provides that both licensees and their employees may not sell or give tobacco products to individuals known to be under the legal age, or to individuals who are not clearly older or who do not have appropriate proof of age such as a driver's license. It also bans entirely sales of "broken packs" (cigarettes are sometimes sold one-by-one to minors), vending machine sales, and sales other than at licensed outlets.

Two of these provisions raise significant questions. First, why age 19, when alcohol purchase is illegal below age 21 and most states now ban tobacco sales at age 18 or below? To the significant extent that tobacco, like alcohol, has been an adult privilege to which many teenagers turn at the first legal opportunity, raising the age will postpone

such exposure until the adolescent has reached an age at which mature judgment has a better chance of overcoming the intense pressure to experiment with "adult" behaviors. This postponement may be even more important for tobacco than for alcohol, since nicotine is rapidly addicting. Even a month or so of regular smoking is likely to create a lifelong addiction for most persons. Also, a realistic appraisal must concede that most teenagers a year younger than the legal age can readily obtain tobacco products from friends who can legally purchase them. Thus, an age 18 limit exposes most 16 and 17 year old youth to an easily exercised temptation. Only if the age limit is at least 19 can the state be confident that most high school students will not have ready access to tobacco. Of course, a few teenagers will be able to obtain such products from family or older friends; the issue here is ready access for most teenagers. Finally, only if the age limit is at least 19 will smoke-free school policies be fully enforceable--no students will have legal access to tobacco products. States are encouraged to consider age 21; this will parallel alcohol practice and also protect older teenagers during years in which many are still vulnerable.

Second, why ban vending machine sales? The basic problem with these sales is that they do not require human intervention--the active participation of a clerk who sells the product only after observing or checking age. Vending machines are often used now by adolescents, and vending machines will nullify otherwise effective action preventing over-the-counter sales. Sales personnel at a register cannot effectively police even nearby machines while serving other customers. Individual states may wish to consider two variations: allowing vending machine sales in places which minors may not legally enter at all, or electronic disabling devices which require positive action by a clerk to activate. However, Utah found that disabling devices were ineffectual in practice. Finally, states could consider allowing a grace period for elimination of these machines to minimize disruption.

Section 6 prohibits unlicensed sale or distribution of tobacco products. It allows exceptions for distribution by relatives or friends on private property not open to the public (e.g., the home) and for wholesale distribution. Section 7 provides for a fine of up to $1,000, and imprisonment of up to 30 days, for unlicensed sale or distribution.

Section 7 establishes two types of financial penalties for violations committed at licensed outlets--civil money penalties and fines. These financial penalties apply both to license holders and sales personnel. Sales personnel are subject to penalties both to emphasize their responsibility under the law and to protect employers against the carelessness of employees. Financial penalties rise progressively with repeated offenses, and are designed to avoid penalizing compliant stores for truly isolated lapses occurring over wide periods of time. A license holder may also avoid one penalty in any two year period by showing that an effective system to prevent violations is in place, i.e., that the sale was a true lapse. The suggested penalty for a first offense is $100 and no suspension; the fourth violation brings a $1,000 dollar fine and a 9 to 18 month suspension of the license. In effect, law abiding stores have nothing to fear; persistent offenders will lose the right to sell tobacco products to adults.

The Department of Health and Human Services has found that use of civil money penalties assessed through administrative law judges rather than the courts has greatly improved the effectiveness and efficiency of enforcing various statutes related to fraud

and abuse. The capacity of the Federal criminal justice system is so stretched that without the alternative of civil money penalties, many "minor" frauds or other crimes simply could not be prosecuted. States face similar constraints. Using civil money penalties is not an "either-or" choice--under existing Federal law, both civil and criminal remedies are available and the choice of which to use in particular cases greatly facilitates effective enforcement. The advantage of this added tool is not only case-specific but systemic: the mere existence of a credible and workable civil money penalty raises the potential cost of statutory violations, and thereby deters violations.

Although the model law emphasizes civil money penalties, fines are authorized as well to provide an enforcement role for both state and local authorities and to provide flexibility of approach. For any particular instance of noncompliance, only one financial penalty may be assessed. Any penalties assessed at the local level must be reported to the Tobacco Control agency so that this agency can accumulate records needed for license suspensions.

Thus, the model law allows the following kinds of flexibility:

o The Tobacco Control agency may develop a backlog of cases requiring hearings. If so, it may bring cases before a local court seeking fines rather than civil money penalties.

o A particular county may be a substantial distance away from agency offices and this may inconvenience retailers, witnesses, and enforcement personnel. The agency can reduce this inconvenience by using local courts.

o Some counties may have both investigator staff (e.g., county health officer) and court capacity to conduct an aggressive enforcement program, beyond the capacity of the state agency. If so, these counties can investigate and seek fines in the local courts. This will simultaneously improve enforcement in these counties and free up state resources for others.

The model law does not address disposition of proceeds from either civil money penalties or fines. Absent specificity, we assume that in most states the former would accrue to the state treasury and the latter to county or city treasuries. This provides an additional benefit of allowing either approach to enforcement: cities and counties can invest in enforcement without financial loss. Of course, a state could elect to earmark revenues differently.

Section 8 provides for license suspension, revocation, and nonrenewal. Starting with the second offense, there are progressively steeper periods of suspension: seven days for the second offense, up to 9 to 18 months for the fourth violation. Section 8 also provides for suspension of licenses for all outlets of a chain if more than three outlets have violated the law more than three times in a two year period. This provision creates a strong incentive for retail chains to ensure compliance by all of their outlets.

Other Matters. The model law does not prohibit purchase or possession of tobacco products by minors. Some states and communities already prohibit these and others may wish to consider this. We left out such provisions because in our judgment they

would be far harder to enforce--and of less relevance to preventing widespread availability--than prohibitions on sales. Such provisions also raise such issues as use of minors as sales clerks; establishment of enforcement procedures; establishment of penalties (small fines, community service, or attending smoking cessation programs are commonly proposed); and possible need to exempt purchase by minors in supervised "sting" operations. Regardless, any underage person smoking in public would indicate a potential violation of the sales ban even absent a possession or purchase law. Authorities could investigate the source of these tobacco products whether or not purchase or possession were banned. States willing to invest in enforcement for both sales and possession should consider adding possession prohibitions.

Finally, while the model law provides for a significant local role in enforcement, it does not provide for independent local statutes. States might wish to empower municipalities to levy higher fines or otherwise exercise some independent authority. The worst possible outcome would be to enact a state statute which failed to establish an effective and workable enforcement system while preempting local governments from filling this void.

Conclusion

Existing state laws prohibiting sales of tobacco products to minors have largely been ineffectual. This enforcement failure is hypocritical and contributes to a scoff-law environment. Unlike some other law enforcement problems, this is neither inherent or insuperable. Eliminating virtually all sales to minors does not even present particularly difficult enforcement problems. It simply requires workable procedures which create swift and sure sanctions for violations, with minimal cost or inconvenience to retailers and adult customers. There is a large and articulate body of citizenry--including a large proportion of teenagers and retailers--who understand the gravity of tobacco consumption as a public health problem and who would welcome reasonable laws. Enactment and responsible implementation of this model law is the single most important reform to improve the health of its citizens that any state could undertake in the decade of the 1990s.

MODEL SALE OF TOBACCO PRODUCTS TO MINORS CONTROL ACT

SECTION 1. SHORT TITLE.

This Act bay be cited as the "Sale of Tobacco Products to Minors Control Act."

SEC. 2. FINDINGS.

The Legislature finds that—

(1) approximately 390,000 Americans die each year of diseases caused by cigarette smoking,

(2) the Surgeon General of the Public Health Service has determined that smoking is the leading cause of preventable death in this country,

(3) nicotine in tobacco has been found by the 1988 report of the Surgeon General, *The Health Consequences of Smoking: Nicotine Addiction*, to be a powerfully addictive drug, and it is therefore important to prevent young people from using nicotine until they are mature and capable of making an informed and rational decision,

(4) most adults who smoke wish to quit, a majority of current adult smokers have tried to quit without success, and one-half of all teenagers who have been smoking for five years or more have made at least one serious but unsuccessful attempt to quit,

(5) every day more than 3,000 minors begin smoking,

(6) one-half of smokers begin before the age of 18, and 90 percent begin before the age of 21, and

(7) minors spend more than one billion dollars on cigarettes and other tobacco products every year.

SEC. 3. OFFICE OF TOBACCO CONTROL.

(a) ESTABLISHMENT OF OFFICE.—There is established in the Department of ——— an Office of Tobacco Control. The Office shall be headed by a Director.

(b) FUNCTIONS OF DIRECTOR.—The Director shall—

(1) issue licenses for the sale of tobacco products,

(2) provide without charge signs (concerning the prohibition on sales to individuals under 19 years of age) that meet the requirements of subsection (d) to persons licensed to sell tobacco products,

(3) investigate (concurrently with other State and local officials) violations of sections 4 through 6,

(4) enforce civil money penalties under section 7,

(5) enforce (concurrently with other State and local officials) fines under section 7, and

(6) bring license suspension, revocation and nonrenewal actions under section 8.

(c) LICENSES.—

(1) A license for the sale of tobacco products shall be issued to a specific person for a specific outlet (a fixed location or mobile unit) and shall be valid for a period of one year.

(2) The annual fee for a license is $50 for an outlet whose annual volume of tobacco sales is less than $5000, and $300 for an outlet whose annual volume of tobacco sales is $5000 or more.

(d) SIGNS CONCERNING SALES TO INDIVIDUALS UNDER AGE 19.—Signs to be provided under subsection (b)(2) shall—

(1) contain in red lettering at least one-half inch high on a white background "IT IS A VIOLATION OF THE LAW FOR CIGARETTES OR OTHER TOBACCO PRODUCTS TO BE SOLD TO ANY PERSON UNDER THE AGE OF 19," and

(2) include a depiction of a pack of cigarettes at least two inches high defaced by a red diagonal diameter of a surrounding red circle.

SEC. 4. DISPLAY OF LICENSE AND SIGNS.

A person that holds ~~a license issued~~ under section 3(b)(1) shall—

(1) display the license (or a copy) prominently at the outlet for which the license is issued, and

(2) display prominently at each place at that outlet at which tobacco products are sold a sign that meets the requirements of section 3(d).

SEC. 5. PROHIBITIONS APPLICABLE TO LICENSE HOLDERS AND THEIR EMPLOYEES AND AGENTS.

(a) PROHIBITION ON SALE OR DISTRIBUTION TO INDIVIDUALS UNDER THE AGE OF 19 AND IN CERTAIN OTHER CASES.—A person that holds a license issued under section

3(b)(1), or an employee or agent of that person, may not sell or distribute a tobacco product—

(1) to any individual that the license holder, employee, or agent knows is under 19 years of age,

(2) to any individual (other than an individual who appears without reasonable doubt to be over 19 years of age) who does not present a driver's license (or other generally accepted means of identification) that describes the individual as 19 years of age or older, contains a likeness of the individual, and appears on its face to be valid,

(3) in any form other than an original factory-wrapped package, or

(4) other than at an outlet for which a license has been issued under section 3(b)(1).

(b) PROHIBITION ON MAINTAINING VENDING MACHINES.—A person that holds a license issued under section 3(b)(1) or an employee or agent of that person, may not maintain at a licensed outlet any device that automatically dispenses tobacco products.

(c) NO MORE THAN ONE VIOLATION ON ANY ONE DAY.—No person shall be liable under the preceding subsections for more than one violation on any one day.

SEC. 6. PROHIBITION ON UNLICENSED SALE OR DISTRIBUTION OF TOBACCO PRODUCTS.

(a) GENERAL RULE.—No person, other than a person who holds a license issued under section 3(b)(1), or an employee or agent of that person, may sell or distribute a tobacco product.

(b) EXCEPTIONS.—Subsection (a) does not apply to—

(1) distribution by an individual to family members or acquaintances on private property that is not open to the public, or

(2) the sale or distribution to a manufacturer of tobacco products, to a wholesaler of tobacco products, or to a person who holds a license issued under section 3(b) (I)

SEC. 7. PENALTIES.

(a) NATURE AND SIZE OF PENALTIES.—

(1) Any license holder that violates a requirement of section 4 shall be subject to a fine or civil money penalty of not more than $100.

(2) Any license holder, employee, or agent that violates a prohibition of section 5 shall each be subject to—

(A) a fine or civil money penalty of $100, for the first violation within a two year period,

(B) a fine or civil money penalty of $250, for the second violation within a two year period,

(C) a fine or civil money penalty of $500, for the third violation within a two year period, or

(D) a fine or civil money penalty of $1000, for any additional violation within a two year period.

(3) Any person that violates a prohibition of section 6 shall be subject to a fine of not more than $1000, or imprisonment of not more than 30 days, or both.

(b) EXCEPTION FOR LICENSE HOLDER.—A person that holds a license issued under section 3(b)(1) shall not be subject to a fine or civil money penalty under subsection (a)(2) for a violation by an employee or agent of a prohibition under section 5, and an assessment of a fine or civil money penalty under subsection (a)(2) for a violation by an employee or agent shall be disregarded for purposes of section 8(a), if the license, holder affirmatively demonstrates that the license holder has an effective system in place to prevent violations of the prohibitions under section 5. The exception prescribed by the preceding sentence applies only once to a license holder during any two year-period.

(c) NO DOUBLE PENALTY.—

(1) If an action has been commenced against a person under subsection (a)(1) or (a)(2) for a particular violation for the payment of a fine, no action may be commenced against that person for that violation for the payment of a civil money penalty.

(2) If an action has been commenced against a person under subsection (a)(1) or (a)(2) for a particular violation for the payment of a civil money penalty, no action may be commenced against that person for that violation for the payment of a fine.

(d) Notification to Office of Tobacco Control of Fines Imposed.—A court shall notify the Director of the Office of Tobacco Control of any fine imposed under subsection (a)(2)

SEC. 8. SUSPENSION, REVOCATION, AND NONRENEWAL OF LICENSES.

(a) SUSPENSION, REVOCATION, AND NONRENEWAL OF INDIVIDUAL LICENSES.—A license issued under section 3(b)(1) for a particular outlet shall be suspended or revoked, and not renewed, for a period of—

(1) 7 days, if a fine or civil money penalty has been imposed under section 7(a)(2) for the second violation at that outlet within two years,

(2) 1 to 6 months, if a fine or civil money penalty has been imposed under section 7(a)(2) for the third violation at that outlet within two years, or

(3) 9 to 18 months, if a fine or civil money penalty has been imposed under section 7(a)(2) for any additional violation at that outlet within two years.

(b) SUSPENSION, REVOCATION, AND NONRENEWAL OF ALL LICENSES FOR OUTLETS UNDER COMMON OWNERSHIP OR CONTROL.—All licenses issued under section 3(b)(1) for outlets that are under common ownership or control shall be suspended or revoked, and not renewed, for a period of 9 to 18 months, if fines or civil money penalties have been assessed under section 7(a)(2) for three or more violations at three or more outlets within a two year period.

(c) NO DOUBLE COUNTING.—A violation committed by an employee or agent, and attributed to a license holder, shall be counted only once for purposes of the preceding subsections.

(d) EXCEPTION.—See section 7(b).

PREPARED STATEMENT OF ROBERT D. TOLLISON

Mr. Chairman, and members of the Committee, my name is Robert D. Tollison. I am Duncan Black Professor of Economics at George Mason University in Fairfax, Virginia. I have published numerous scholarly articles and books in the field of economics, and I have served in the Federal government twice, once as a Senior Staff Economist on the Council of Economic Advisers and once as Director of the Bureau of Economics at the Federal Trade Commission. I am appearing here today on my own behalf at the request of the Tobacco Institute to comment specifically on the alleged "social cost" of smoking.

One of the most superficially appealing arguments that has recently surfaced is the idea that smokers should pay more of the costs of publicly-funded health care programs because they allegedly benefit more than nonsmokers from the services so provided. Advocates of such "user fees" typically contend that there are "social costs" associated with smoking, including lost work time due to illnesses said to be related to smoking, costs incurred by Medicare and other programs in treating such diseases, and so forth. Such allegations are misleading because they confuse private costs and social costs. If, as some argue, smokers indeed face increased health risks, individuals bear the related "costs" in the form of reduced wages and higher insurance premiums. To also count these costs as social costs represents a simple and erroneous double counting. In point of fact, if one looks carefully at studies of the so-called social costs of smoking, one will see that the only constant in such studies is confusion of basic economic principles. Properly analyzed, the facts support only one conclusion—smokers pay their own way in our society; there are no "social costs" of smoking.

Of late, the principal study of the alleged social costs of smoking is Smoking and Health: A National Status Report, issued by the Office on Smoking and Health of the Department of Health and Human Services. This report and Secretary Sullivan's remarks about smoking before the Senate Labor and Human Resources Committee made headline news across the country.

The basic claim in Smoking and Health is that smokers are not paying their own way in our society. It is claimed, for example, that every man, woman, and child in the U.S. pays $221 each year for the health expenses of smokers. The total "costs" of smoking to the nation are asserted to be $52 billion every year. Smoking and Health even parses out these costs on a state-by-state basis, ranging from a low of $56 a person in Utah to $284 in Rhode Island. Unfortunately, the report and Dr. Sullivan's testimony do not constitute a basis for sound public policy. All of this activity is being driven by an economic analysis of the "costs" of smoking, such as that contained in Smoking and Health, that is mired in confusion and fallacy.

Of course, Smoking and Health is a lineal descendant of prior government studies of smoking. There have been several reports by the Surgeon General on the alleged hazards of smoking. Similarly, in the 1985 report of the Office of Technology Assessment, Smoking Related Deaths and Financial Costs, smoking was held responsible for $40 to $100 billion in costs attributed to diseases associated with smoking. Confusion about the simple economics of smoking appears to be persistent in the Federal

government. To see why, a couple of questions need to be addressed. I use the HHS study as a frame of reference, and ask: What are the claimed costs of smoking in the HHS report and what do they mean?

MORTALITY COSTS

It is clear that thousands of people die each year before their allotted four score and ten years. Many of these deaths are attributed to such activities as driving, parachuting, swimming, and boating, to name a few. There has been a tendency among analysts to label such deaths as "premature," as if the risk of dying while engaging in one's favorite activity was not freely chosen. Such a concept of early death is completely arbitrary and can lead to misleading applications of economic analysis.

Suppose that consumers make well informed choices. These choices by the individual are voluntary choices. There is no compulsion forcing the worker into the risky occupation or into motorcycling cn weekends or into smoking. The individual confronts the risks embodied in these activities and makes his choices accordingly. If this person dies in a motorcycle wreck, there is no presumption that there is a social cost involved related to his lost product.

By itself, the loss of a person's productivity cannot constitute a "cost" to society. To argue otherwise would imply that the worker is the property of society. The death of a person becomes equivalent to the death of a steer on a ranch or the breakdown of a machine in a factory. The rancher or the factory owner would certainly place a value upon their loss. Both instances are essentially identical, in that they represent situations in which owners of assets are confronted with the loss of those assets. By extension, a worker who elects early retirement, or chooses to earn less than his maximum potential, or takes an unpaid leave of absence would also impose a "cost" on society.

But who bears the loss of a premature death? It is clearly the individual who chooses to engage in these activities. Merely to ask the question exposes the fallacy in the common formulation of this problem. While this kind of analysis may be appropriate for machines and domesticated animals, it is clearly inappropriate for the inhabitants of a free society.

Viewed in this light, the typical analysis of the "costs" of premature death attributed to such activities as smoking is meaningless. Individuals choose their lifestyles in such a way as to promote their general well-being as they construe it. These lifestyles will obviously vary immensely. Some people will find smoking preferable, and some not. Some will die young, and some will die old. Generally, however, the date of their death is an expression of such factors as their free will, their luck, and their genetic heritage, among many other circumstances. It is totally inappropriate to treat individuals like machines that have broken down, bringing economic loss to their owners.

In sum, then, the "costs" of death due to a freely chosen activity are really not a cost to society at all. The way these estimates are typically derived yields an essentially meaningless figure. The lost production due to early death is only relevant to the individual who dies early. The consequences of early death are thus internalized into individual choices in the economy, and it is meaningless to count the value of these consequences as a social cost of consumption activity. I89Morbidity Costs

There have been numerous efforts to estimate the claimed morbidity costs of smoking. While the particular estimates obviously differ among countries, and while different estimates can also differ within the same country, the procedure used to develop these estimates has been practically identical in the various instances. The basic procedure is quite simple. All that is required for its application is an estimate of the days of work allegedly lost due to smoking-related morbidity and the value of the production lost because of a day's absence from work. To illustrate the procedure, suppose that it is estimated for some firm or economy that 100 days of work are lost because of illness attributable to smoking. What is the cost of this loss of work? Basic economics says that the value of one day of lost production is equivalent to the daily wage rate of those who are absent from work. Suppose this daily wage rate is $50. If so, the cost of the lost production due to smoking-related morbidity would be $5,000—(100 days of work lost) ($50 per day of lost output).

This standard approach to the social cost of sick leave represents one more illustration of a confusion about the nature of costs. In particular, this approach results in double-counting, which is a mistake that frequently creeps into economic analyses of possible public policies toward smoking. The common error with respect to sick leave can be illustrated quite simply. Suppose that smokers miss work because of sickness more frequently than nonsmokers. As shown above, it is typically suggested that the greater absenteeism of smokers, when multiplied by their wage rate,

will give a measure of the "cost" of smoking due to sickness. However, it might reasonably be expected that a person who misses more work than another will receive lower earnings. This lower income would reflect the cost of smoking, and this cost would be borne by the smoker. To count this cost as also a social cost would be to count the same amount twice. Whenever such costs are reflected in market-determined compensation, there exists no uncompensated cost of absenteeism, so to count the lost production due to absenteeism would be to count the same amount a second time.

One factual point should be made in concluding this discussion of the claimed morbidity costs of smoking. There is frankly no conclusive evidence to support the claim that smokers are less productive workers than nonsmokers. In fact, there is some evidence to the contrary. Thus, the whole argument along these lines may be a red herring.

HEALTH CARE COSTS

It will be useful to begin the discussion of health care costs by reviewing how researchers have derived estimates of the medical expenses for treating illnesses that have been associated with such activities as smoking. I then proceed to consider the reasonableness of counting these costs as "social costs," taken to mean costs for which there is some public policy rationale to do something about.

The method used to estimate the medical care cost of smoking is straightforward. A figure is derived for total medical expenses, an estimate made of the share of those expenses attributed to smoking, and a figure for the medical cost of the activity subsequently derived.

For instance, suppose a hospital's annual expenses were $20 million. Further, suppose the number of patient- or bed-days provided by the hospital during the year were 100,000, giving an average daily expense per-patient per-bed of $200. The question arises as to how much of the hospital's expenses to attribute to illnesses related to smoking. If it were assumed that 20 percent of the beds were occupied with smoking-related illnesses, and, moreover, if it were assumed that the treatment of such illnesses made an average claim upon hospital resources, $4 million would be attributed as the hospitalization cost due to smoking. The same procedure would be used to provide an estimate of the expenses of physician services used to treat such illnesses. Notice that I talk here not in terms of causal but in terms of assumed relationships.

Although this procedure for estimating the medical costs associated with various activities is a standard one, it is not without its defects. Primarily, if people pay their own medical expenses, no issue of "social cost" can arise. In this setting people are using resources in their capacities as consumers that they have provided for themselves in their capacities as producers. Issues of "social cost" can arise only if part of one person's medical expenses are borne by others. In detecting whether or not this is happening, something more must be done than simply assessing the flow of payments. An observation that for some set of people their medical expenses exceed their medical payments does not mean that other people are subsidizing their medical expenses. The people under consideration may belong to an insurance program. When viewed after the fact, insurance appears to be a program in which those who have claims are subsidized by those who do not. But the appropriate perspective toward insurance is before the fact not after. When looked at before the fact, all participants must look upon their participation as beneficial to them, for otherwise they would not have chosen to participate. Private insurance is an illustration of how something that might look like a subsidization of some people by others has a quite different underlying reality than its outward appearance might suggest.

To the extent that health resources are consumed by smokers, as the result of claims on private insurance policies, the consumption of these resources in no way constitutes a social cost or a social problem. To count them as such is to count the cost of these resources twice, once in the price of insurance and again in the actual consumption of medical resources. This procedure is fallacious from the point of view of the whole economy.

But there are yet more complicated issues related to singling out the usage of health care resources by smokers. For example, suppose a young motorcyclist suffers an accident. He dies of head injuries because he was not wearing a safety helmet, and his widow collects pension payments. Such payments are routinely classified as income transfers The young man enjoyed the benefits of motorcycling, but through his failure to wear a helmet, he created a situation in which everyone must now pay his widow's pension. Do these payments represent a social cost?

The income transfer was, in effect, created by the state (or by society) when it was decided to provide collectively for widows. If we try to go beyond this and specify that some applications of the policy constitute "social costs" while others do not, absurdities quickly enter and with no reasonable or logical basis for excluding them. The widow of a fat man or a football player must also, by the same criteria, create a "social cost." Also perhaps vulnerable to the charge of creating a "social cost" are people who work too hard, who do not get the right vitamins, who do not exercise adequately, and so on. Again, I am not suggesting causal relationships here, but pointing to the types of conceptual issues that can easily arise in this area. In any event the state created the income transfer, and with it any possible social cost, not the injured or deceased.

The point of contention about transfers reduces to one of the right of access to state-provided benefits and to the conditions placed upon that access. This is a matter on which economics has little to contribute. What contribution it can make is to note that the mere presence of a transfer system does not legitimize a claim that the recipients of transfers are imposing social costs on the remainder of society.

Equity considerations have also been injected into discussions of the subsidization of some peoples' medical expenses by others, often under the claim that the tax-transfer system which subsidizes medical expenses provides an unfair subsidy to smokers, among other people. The problem with this argument is that there is no clear way to draw the line between smoking, which is seen as a form of voluntary risk, and such activities as skiing, eating too much, swimming, driving, and sundry other activities that may influence health and longevity. All of these activities are personal choices in the same sense as is smoking. To try to draw a distinction between these various possibilities would seem clearly to be improper. To attempt to draw such distinctions, moreover, would, when drawn to its logical conclusion, be to place before the public agenda the regulation of practically all facets of personal life, an outcome that few would relish.

In summary, income transfers take place all the time. The net effect of any one person's lifestyle may ultimately leave him a "benefactor" of others or a "debtor" to others in the sense that either more or less was actually taken from him in taxes than he had received through various transfer programs. It is this, above all else, that makes it impossible to say that any particular income transfer constitutes an unfair or social cost: any particular program represents only one of many such transactions the individual has within an entire network of tax-transfer relationship.

CONCLUDING REMARKS

The HHS study leaves no stone unturned in its recommendation and review of policies to subdue smokers. It is clear, however, that these anti-smoking efforts have two fundamental goals.

One is to increase the excise tax on tobacco products. Anti-smoking lobbyists obviously see an increased excise tax as a tool not only of social control, but also as a revenue source through which to expand a variety of government programs. However, not only does an excise tax on smokers have no analytical basis, as argued heretofore, but such a tax is one of the worst taxes in the fiscal arsenal of government.

The excise tax on tobacco products is one of the most regressive taxes that presently exists in the U.S. In other words, it is a tax on poor people because they pay a disproportionate percentage of their income in these taxes. Anti-smoking advocates obviously feel that it is viable public policy to reduce the income of poor individuals and families in the U.S. by, say, $300 per year. This, needless to say, is a lot of disposable income to low-income families.

Moreover, an increase in the tobacco excise tax would not actually deter very much smoking. Estimates of the responsiveness of smokers to price and tax increases suggest that they will not smoke very much less if their taxes are raised. Thus, the only true rationale for the recommendation to raise the excise tax would have to be to raise revenue and not to deter smoking. But, alas, why raise revenue from a regressive tax on poor people?

There is a movement in the U.S. toward tax reform and more tax justice. The imposition of further regressive excise taxes is inconsistent with this movement. An increase in a regressive excise tax is out of step with the movement toward more tax justice in the country at large.

The second major item on the agenda of the anti-smokers is to increase the size and regulatory scope of government. Using fallacious reasoning about the claimed "social costs" of smoking, as outlined above, Secretary Sullivan and others would seek to expand radically the regulation of smoking through government programs. Such proposals should be seen for what they are—an employment act for the anti-

smoking movement. They simply represent another government program that we do not need.

As Smoking and Health reports, smokers now constitute roughly 25 percent of the adult population in the U.S. This fact alone makes it quite apparent that smokers are an easy target in a regime of majoritarian politics. But this is exactly the point that should be recognized. The anti-smoking lobby does not have the science of economics on its side. To the contrary, they have erected a pseudoscientific economic case against smoking that an elementary economics student could see through. What they are, pure and simple, is a majority picking on a minority.

PREPARED STATEMENT OF CHARLES O. WHITLEY

Mr. Chairman and distinguished members of the Committee. I appreciate the opportunity to appear before you today on behalf of The Tobacco Institute. The Committee's press release of May 10, 1990, indicates that this hearing will consider "the monetary and social costs of smoking" and "alternative approaches to help discourage young people from starting to smoke and encourage people who already smoke to quit." In my testimony, I will describe the tobacco industry's initiatives to assist in discouraging youth from smoking. I also will address the suggestion that Congress should increase the Federal excise tax on cigarettes, as Senator Chafee has proposed (S. 801). Finally, I will discuss legislation, introduced by Senator Bradley, that would disallow tax deductions for tobacco advertising expenses (S. 776).

I am accompanied by Larry C. Holcomb, Ph.D., an environmental toxicologist. Dr. Holcomb is prepared to answer questions concerning environmental tobacco smoke and children, an additional issue mentioned in the Committee's press release.

1. *Youth Initiatives.*—Mr. Chairman, the cigarette industry does not want young people to smoke. We believe that smoking is for those adults who choose to smoke. I know of no other industry in America that has taken such direct, voluntary action to steer its products away from young people.

In 1964, the cigarette manufacturers adopted a Cigarette Advertising Code. Among other things, the Code prohibits cigarette advertising in publications directed primarily to persons under 21. The manufacturers also subscribe to a Code of Sampling Practices prohibiting cigarette sampling to persons under 21 and imposing other stringent safeguards in this regard. In 1969, the cigarette industry offered voluntarily to stop advertising on television and radio. Cigarette advertising left the air in 1970 as a result of Federal legislation giving effect to that proposal.

In 1982, The Tobacco Institute launched a national advertising campaign that reached 110 million Americans. The message was, "Do cigarette companies want kids to smoke? No. As a matter of practice, No. As a matter of fact, No." In 1984, as part of its Responsible Living Program, The Institute began offering a free guide book for parents, "Helping Youth Decide," prepared in conjunction with the National Association of State Boards of Education (NASBE). More than 700,000 copies of this guide and its sister publication, "Helping Youth Say No," have been distributed nationwide, and we continue to offer the booklets free of charge upon request. These booklets provide guidance on family communications to help youngsters develop decisionmaking skills needed to deal wisely with everyday choices and lifestyle decisions, such as smoking.

This and other aspects of the Responsible Living Program are described in greater detail in the attached statement of Jolly Ann Davidson, national spokesman for the Responsible Living Program.

2. *Excise Taxes.*—Mr. Chairman, we oppose any further increase in the Federal excise tax on cigarettes. Cigarettes already are the most heavily taxed consumer product in America. Smokers paid over $11 *billion* in FY 1988 in Federal, State and local taxes on cigarettes. In the last ten years, moreover, cigarette excise tax increases have far exceeded the rate of inflation. Cigarette excise taxes have risen 87 percent since 1980—from 21.1 cents a pack in 1980 to 39.4 cents a pack in 1990. By contrast, the Consumer Price Index rose by only 50 percent during the same period. In 1989 alone, cigarette excise taxes increased by 50 percent or more in seven states. Within California alone, the tax jumped 250 percent last year. Those seven states (California, New York, Illinois, Connecticut, Nevada, Alaska and Wyoming) account for more than 25 percent of the total U.S. population.

Like all consumer excise taxes, cigarette excise taxes are inherently regressive. The Congressional Budget Office reported in 1987 that a cigarette excise tax increase would hit lower-income families more than six times harder than higher-income families. Indeed, the CBO, which studied the distributional effects of excise tax increases on beer, wine, liquor, tobacco, gasoline, airfare and telephone service,

concluded that "[a]n increase in the excise tax on tobacco would be the most regressive of all." [1] A Black Congressional Caucus Task Force report released by Rep. Mervyn Dymally (D-Cal.) states that "even a modest increase in excise taxes" would negate the relief afforded to the poor in the Tax Reform Act of 1986 and would "considerably magnify the incidence, prevalence and the enormity of poverty in the United State." [2] A burdensome and discriminatory tax should not be made even more burdensome and discriminatory. On the issue of cigarette excise taxes the time has come to say, "Enough is enough."

The argument sometimes is made that the cigarette excise tax should be increased to offset the supposed "social costs" of smoking. Mr. Chairman, this argument is without merit. As Dr. Robert D. Tollison, a professor of economics at George Mason University, will explain in his testimony, smoking and smokers do not impose costs on society. Much has been made of a recent assertion by Dr. Louis Sullivan, the Secretary of Health and Human Services, that smoking "costs" society $52. billion a year. Secretary Sullivan was careful to note, however, that this figure does not factor in the contributions of tobacco to society in terms of jobs, excise taxes, etc.[3] Moreover, such assertions would have us believe, for example, that society "owns" the productivity of smokers. As Dr. Tollison will explain more fully, these assertions fail to consider that if there are any "costs" associated with smoking, they are "private costs" borne by the individual. These statistical manipulations also fail to consider studies reporting, for example, that smokers are no less productive than their nonsmoking co-workers.

Mr. Chairman, taxing smokers to offset the supposed costs of their smoking is a misapplication of the taxing power. The tax system should not be used to regulate personal lifestyle choices. Obesity has been estimated to "cost" society about $27 billion a year.[4] Yet no one would seriously suggest that we tax people who weigh more than 20 percent over their ideal weight to discourage obesity. Softball sliding injuries reportedly "cost" society at least $2 billion a yearly.[5] No one would seriously suggest that we impose a special tax on folks who play softball to offset those "costs." Viewed from this standpoint, imposing special taxes on smokers is both discriminatory and punitive.

Some suggest that the cigarette excise tax should be increased to discourage smoking. Any significant increase in the Federal cigarette excise tax may discourage smoking to *some* extent, resulting in lost jobs, lost farm income and other adverse economic effects. Nevertheless, the antismoking lobby has exaggerated the effectiveness of excise tax increases as a means of reducing smoking, especially among teenagers. The most marked decline in smoking prevalence in the past decade—a period during which the price of a pack of cigarettes increased nearly 40 percent in constant dollars was among white males at higher income levels. It is difficult to believe that decisions by members of this group not to smoke are attributable, to any significant extent, to economic considerations.

---

[1] CBO, "The Distributional Effects of an Increase in Selected Federal Excise Taxes," pp. 1-2 (Jan. 1987). The CBO found that people earning between $5,000 and $9,000 per year paid, as a percentage of current income, over six times more in cigarette excise taxes than those earnings $50,000 or more. Attempting to measure regressivity on a permanent income" basis as well, the CBO study found that people in the $5,000-$9,000 category still pay, as a percentage of income, over 2.7 times more in cigarette excise taxes than those in the $50,000 and above category. As a recent report prepared for the Coalition Against Regressive Taxation (CART) explains, current income is a more realistic basis for measuring ability to pay an excise tax than "permanent income." Low-income families must confront reality as it currently exists. The fact that a family's income may rise in the future is not going to pay the bills today. Tax payments cannot be deferred until better times. For this and other reasons, most empirical studies of the distributional effects of taxes use some measure of current income as the basis for the analysis. See KPMG Peat Marwick, "Changes in the Progressivity of the Federal Tax System: 1980 to 1990," p. A-5 (April 1990).

[2] Report for the Chairman of the Congressional Black Caucus, "Analyzing the Possible Impact of Federal Excise Taxes on the Poor, Including Blacks and Other Minorities," p. 4 (July 1987).

It has been suggested that the regressivity of a cigarette excise tax increase for lower-income groups could be offset by increasing the earned income tax credit (EITC). But increasing the EITC to offset regressivity would mean giving up revenues and thus defeat the purpose of raising excise taxes to reduce the Federal deficit. And, increasing the EITC would benefit only low-income wage earners with dependents who earn enough to file tax returns. It would not offset regressivity for other low-income wage earners, the unemployed or the elderly poor who rely on Social Security and other non-wage sources of income. Finally, increasing the EITC would leave the tax burden spread unevenly within the lower-income groups.

[3] Smoking and Health: A National Status Report 40-41 (2d ed. 1990).

[4] "Health Care Costs of Obese People," American Demographics, Oct. 1987.

[5] Morbidity and Mortality Weekly Report, March 25, 1988.

Last June, GAO issued a report claiming that a 20-cent tax increase would significantly reduce youth smoking.[6] With respect, Mr. Chairman, the GAO paid too much attention to dated analyses and too little attention to the facts.

Cigarette prices in constant dollars increased from about 75 cents a pack in 1981 to nearly $1.05 a pack in 1988—a 40 percent increase.[7] During the same period smoking prevalence remained essentially unchanged among high school seniors—an "almost flat trend," in the words of the GAO.[8] Between 1980 and 1983, prevalence fluctuated between 21 and 20 percent. Between 1984 and 1987, prevalence fluctuated between 18 and 19 percent.[9] The GAO report notes, moreover, that smoking is most prevalent among high school seniors in the Northeast, where cigarette prices are among the highest in the nation.[10] And the report states that the current generation of teenage smokers is more likely to contain people who are "highly resistant" to price increases than earlier generations of teenage smokers.[11]

If teenage smoking prevalence remained essentially unchanged throughout a period during which the price of a pack of cigarettes increased nearly 40 percent, and if teenage smokers today are less responsive to price increases than ever before, how can' the GAO report claim that a 20-cent increase in the Federal cigarette excise tax would significantly reduce youth smoking? The way to reduce youth smoking is through enforcement of state laws prohibiting the sale and distribution of cigarettes to minors—not through increases in a burdensome, discriminatory and regressive consumer excise tax.

3. *Advertising Expense Deduction.*—Senator Bradley's bill (S. 776) would disallow tax deductions "for any amount paid or incurred to advertise any tobacco product." As the attached Legal Memorandum prepared by the law firm of Covington & Burling demonstrates, this bill, like a similar bill introduced by Senator Bradley in the 100th Congress, would violate the First Amendment. The Supreme Court has held repeatedly that the government may not exercise its taxing powers in a manner that discriminates against particular speakers on the basis of their speech. Senator Bradley's proposal would fail under the First Amendment because, among other reasons, cigarette advertising does not cause people to smoke and suppressing cigarette advertising would not cause people to stop or reduce youth smoking.

Senator Bradley has suggested that Congress should no longer "subsidize" cigarette advertising through the advertising expense deduction.[12] The deduction, however, is not a "subsidy." Our tax system is based on the concept that only net income should be taxed. Deductions are permitted for costs reasonably incurred in producing that income. The advertising expense deduction no more "subsidizes" advertising than the payroll expense deduction "subsidizes" the hiring of workers. Expense deductions can be viewed as a "subsidy" only if one is prepared to label every decision not to impose a particular type of tax as a "subsidy." Even if the deduction were a "subsidy," the First Amendment would prohibit the government from making it available only to those whose messages it approves.

Senator Bradley has suggested that cigarette advertising expenses should be disallowed to demonstrate that Congress disapproves of smoking.[13] Apart from the First Amendment issues raised by this position, the precedent set would be a dangerous one. Commenting on this aspect of Senator Bradley's proposal in 1987, the President of the American Bar Association stated, with justifiable irony: "I don't mind that principle if you let me apply it to all the things I dislike. But if you want to apply it to the things you dislike, then I'm worried." The ABA President added that "there's a serious legal problem . . . to the use of [the] tax code for social engineering." [14]

---

[6] General Accounting Office, "Teenage Smoking—Higher Excise Tax Should Significantly Reduce the Number of Smokers," p. 1 (June 1989).

[7] Id. at 6.

[8] Id. at 13.

[9] *Reducing the Health Consequences of Smoking—A Report of the Surgeon General* 303 (1989) (Table 19).

[10] Id. at 14; Tobacco Institute, *The Tax Burden on Tobacco*, vol. 24, p. 102 (1989).

[11] Id. at 7, 26. The GAO suggests that this fact may be offset by the fact that teenage smokers today are more likely to come from lower socio-economic groups than in the past, and therefore are more likely to be price-sensitive. The fact that smoking has declined the least among lower socio-economic groups in the past decade refutes the contention that these socio-economic groups are particularly price-sensitive so far as cigarettes are concerned.

[12] 135 Cong. Rec. S3,915 (daily ed. April 13, 1989).

[13] *Ibid.*

[14] Interview, *Advertising Age*, Feb. 23, 1987, p. 80.

LEGAL MEMORANDUM

A Constitutional Analysis of Proposals to Disallow Tax Deductions for Tobacco Product Advertising Expenses

prepared by

COVINGTON & BURLING

Washington, D.C. 20004

July 1, 1987

This memorandum is an updated version of a memorandum on the same issue dated April 1986. The analysis presented in this memorandum would apply to federal legislation discriminating against advertising for any product—not just legislation discriminating against tobacco product advertising.

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

A Constitutional Analysis of Proposals to Disallow Tax Deductions for Tobacco Product Advertising Expenses

On February 3, 1987, Senator Bradley introduced a bill (S. 446) that, if enacted, would disallow tax deductions "for any amount paid or incurred to advertise any tobacco products." On March 11, 1987, Representative Stark introduced a similar bill (H.R. 1563) that would go even further, prohibiting deductions not simply for tobacco product advertising but for *any* communications "informing or influencing the general public (or any segment thereof) with respect to tobacco and tobacco products." Each bill is identical to legislation introduced by Senator Bradley and Representative Stark in the last Congress (S. 1950 and H.R. 3950).

Senator Bradley has stated that the purpose of his bill is to assure that, when it comes to the use of tobacco products, "the Government [will] speak with one voice," a voice that will "unequivocally say, 'smoking will harm you.' "[1] Representative Stark has stated that his intention is to "significantly decrease" or "end" advertising of tobacco products.[2] Both bills thus seek to suppress disfavored speech through the

[1] 133 Cong. Rec. S1617 (daily ed. Feb. 3, 1987); 131 Cong. Rec. S17,696 (daily ed. Dec. 16, 1985).

[2] 133 Cong. Rec. E893 (daily ed. March 11, 1987); 131 Cong. Rec. H12,203 (daily ed. Dec. 16, 1985).

tax system, by making such speech inordinately expensive.[3]

As attempts to suppress truthful speech proposing the sale of a lawful product, the Bradley/Stark proposals would likely be held unconstitutional under the test outlined by the Supreme Court in the *Central Hudson* case and reaffirmed in *Posadas*. Restrictions on commercial speech cannot be sustained unless, among other things, they "directly advance" a substantial governmental interest and that interest cannot be served by any "less restrictive" means. It is unlikely that the Bradley/Stark proposals could satisfy either of those elements of the governing *Central Hudson* test.

The fact that Senator Bradley and Representative Stark have chosen the tax system to achieve their goal is irrelevant under the First Amendment. As the

---

[3] The Bradley/Stark proposals are only the latest in a series of attempts to use the tax code to penalize disfavored speech or to use a tax on speech as an instrument of social policy. In the last Congress, Representative Stark also introduced legislation (H.R. 1444) to ban tax deductions for arms-sale promotion expenses, and Representative George Brown introduced legislation (H.R. 2657) to ban tax deductions for alcoholic-beverage advertising expenses.

In the current Congress, Representative Donnelly on June 4, 1987, introduced a bill (H.R. 2606) that would disallow tax deductions for advertising of tobacco products *and* alcoholic beverages. Representative Donnelly has stated that advertising for these products should not receive the tax "subsidy" available to advertising for other products. 133 Cong. Rec. H4202 (daily ed. June 4, 1987). In addition, Representative Collins has introduced legislation (H.R. 332) to disallow advertising expense deductions to persons who discriminate in their advertising practices on the basis of race, color or ethnic background.

President of the American Bar Association, Eugene C. Thomas, has stated, "there's a serious legal problem * * * to the use of [the] tax code for social engineering."[4] Neither can the Bradley/Stark proposals be saved, as both legislators have suggested, by characterizing the disallowance of tax deductions for tobacco product advertising as the removal of a federal "subsidy." Whatever may be said of that characterization, the fact is that both proposals would single out one form of speech and—because of its content—attempt to stamp it out. That is precisely what the First Amendment forbids.

* * * *

We first review the Supreme Court's decisions establishing that Congress may not use the tax system to burden or inhibit disfavored speech. We then assess the Bradley/Stark proposals under the First Amendment test for legislation that would ban or restrict commercial speech.[5]

* * * *

---

[4] Interview, *Advertising Age,* Feb. 23, 1987, p. 80.

[5] To the extent that the Stark bill would disallow deductions for *any* communications "informing or influencing the general public (or any segment thereof) with respect to tobacco and tobacco products," it would burden noncommercial as well as commercial speech on the basis of its content. *See, e.g., Consolidated Edison Co.* v. *PSC,* 447 U.S. 530 (1980). No discussion is required to demonstrate that such a burden on noncommercial speech would violate the First Amendment.

I. CONGRESS MAY NOT USE THE TAX SYSTEM TO BURDEN OR INHIBIT DISFAVORED SPEECH

A. The First Amendment Forbids Congress To Exercise the Taxing Power Discriminatorily

Under the First Amendment, the fact that Senator Bradley and Representative Stark have chosen to use the tax system to suppress tobacco-related speech, rather than attempt to achieve that goal more directly, is irrelevant. The Supreme Court has long recognized that "speech can be effectively limited by the exercise of the taxing power" (*Speiser* v. *Randall,* 357 U.S. 513, 518 (1958))—just as it can be limited by more direct types of regulation. Indeed, in a celebrated case decided a half-century ago, the Supreme Court identified "taxes on knowledge" as one of the primary evils the First Amendment was designed to guard against.

The Court was confronted in that case—*Grosjean* v. *American Press Co.,* 297 U.S. 233 (1936)—with a Louisiana tax on large-circulation periodicals imposed to punish critics of Governor Huey Long. The Court invalidated the tax because, like the proposed disallowance of deductions for tobacco product advertising, it was "a deliberate and calculated device in the guise of a tax to limit the circulation of information to which the public is entitled." *Id.* at 250. Like the Bradley/Stark proposals, it also was aimed at the suppression of disfavored speech. *See Minneapolis Star & Tribune Co.* v. *Minnesota Comm'r of Revenue,* 460 U.S. 575, 585 (1983). *See also Arkansas Writers' Project, Inc.* v. *Ragland,* 107 S. Ct. 1722, 1726-28 (1987).

The Supreme Court has twice upheld measures disallowing tax deductions for lobbying expenses pre-

35-777 O - 91 - 6

cisely because Congress had *not* discriminated invidiously in such a way as to "aim at the suppression" of disfavored ideas. In *Regan* v. *Taxation with Representation*, 461 U.S. 540 (1983), the Court rejected a challenge to provisions of the Internal Revenue Code making contributions to nonprofit lobbying groups nondeductible, while permitting deductions for contributions to veterans' lobbying groups. The Court rejected the challenge on the ground that there was "no indication that the statute was intended to suppress any ideas or that it has had that effect." *Id.* at 548.

Similarly, in *Cammarano* v. *United States*, 358 U.S. 498 (1959), the Court upheld a provision of the Internal Revenue Code that disallowed deductions for lobbying by business entities. It upheld the provision because the disallowance for lobbying expense deductions by business groups, which mirrored the treatment of nonprofit groups, was viewpoint-neutral. The statute expressed a uniform determination by Congress that "everyone in the community should stand on the same footing * * * so far as the Treasury of the United States is concerned." *Id.* at 513.

The Bradley/Stark proposals obviously would not leave tobacco product manufacturers "on the same footing" as other advertisers. Both proposals target tobacco product advertising for adverse treatment, and they do so in order to produce "a significant coercive effect." *See Arkansas Writers' Project*, 107 S. Ct. at 1731 (Scalia, J., joined by Rehnquist, C.J., dissenting). Both proposals are "frankly aimed" at suppressing the speech of tobacco product manufacturers because of the content of that speech (*see American Communications Ass'n* v. *Douds*, 339 U.S. 382, 402 (1950))—a result that requires extraor-

dinary justification under the First Amendment regardless of the means chosen to achieve it.[6]

B. The Bradley/Stark Proposals Cannot Be Rationalized as a Mere Refusal To "Subsidize" Speech

Even if the stated aim of the Bradley/Stark proposals were not to "decrease" or "end" tobacco product advertising but simply to assure that the government shall no longer "subsidize" a message with which it disagrees—as Senator Bradley has suggested (133 Cong. Rec. S1616 (daily ed. Feb. 3, 1987))—the proposals would violate the First Amendment.

The "subsidy" justification offered by Senator Bradley is misconceived for two reasons. First, it incorrectly portrays the deduction for advertising expenses as a means by which the government subsidizes speech. In fact, our tax system is based on the premise that only net income should be taxed, with deductions being permitted for costs reasonably incurred in producing that income. The deduction for advertising expenses—like deductions for other ordinary business expenses—simply implements the net income concept. It no more provides a "subsidy" for advertising than the deduction for payroll expenses provides a "subsidy" for the hiring of workers. Ex-

---

[6] In *Arkansas Writers' Project,* the Court this April invalidated as impermissibly discriminatory under the First Amendment a state statute that taxed general-interest magazines but exempted newspapers and religious, professional, trade, and sports journals. Although they disagreed with the Court's decision, Chief Justice Rehnquist and Justice Scalia agreed that denial of participation in a system of tax exemptions *would* infringe the First Amendment if the denial were designed to produce, or did produce, "a significant coercive effect"—*i.e.,* an inhibition of speech. 107 S. Ct. at 1731.

pense deductions can be viewed as a "subsidy" only if one is prepared to label every decision not to impose a particular type of tax as a "subsidy."

Second, even if the advertising expense deduction could legitimately be viewed as a government subsidy, that would not free the government to dole it out to speakers with government-approved messages while denying it to speakers with messages that the government does not like. It is settled, for example, that the government may not restrict expression in public places—for example, public streets and parks, or public libraries and universities—in a discriminatory manner. Each of those "public forums" exists because of a government subsidy. Yet, the Supreme Court has held repeatedly that the government cannot grant or withhold access to such forums—which may be said to constitute a "subsidy in kind" (M. Yudof, *When Government Speaks* 234 (1983))—on the basis of the speaker's message.[7]

Similarly, it is clear that the government may not limit use of the mail system to only those messages that the government favors—even though the public mail service constitutes a direct public subsidy for private communication. *See U.S. Postal Service* v.

---

[7] *E.g.*, *Cornelius* v. *NAACP Legal Defense & Educational Fund*, 105 S. Ct. 3439, 3449-50, 3454-55 (1985); *Perry Education Ass'n* v. *Perry Local Educators' Ass'n*, 460 U.S. 37, 45-46 (1983). *See also Board of Education* v. *Pico*, 457 U.S. 853, 869-72 (1982) (plurality opinion). The nation's airwaves are another example of a public resource that plainly cannot be allocated on the basis of a speaker's viewpoint. *See generally FCC* v. *League of Women Voters*, 468 U.S. 364, 376-81 (1984); *CBS* v. *Democratic Nat'l Committee*, 412 U.S. 94, 162-63 (1973) (Douglas, J., concurring); *Red Lion Broadcasting Co.* v. *FCC*, 395 U.S. 367, 390-91, 396 (1969); *NBC* v. *United States*, 319 U.S. 190, 226-27 (1943).

Council of Greenburgh Civic Assn's, 453 U.S. 114, 141 (1981) (White, J., concurring); *Bolger* v. *Youngs Drug Products Corp.*, 463 U.S. 60, 80 (1983) (Rehnquist, J., concurring); *United States* v. *Van Leeuwen*, 397 U.S. 249, 251-52 (1970). In fact, the Supreme Court has ruled specifically that the government, having made second-class postal rates generally applicable to periodical publications, cannot withhold that subsidy from a disfavored magazine. *Hannegan* v. *Esquire, Inc.*, 327 U.S. 146, 156 (1946).

If the government must make these "subsidies" available on a content-neutral basis, it plainly also must make the advertising expense deduction available on a content-neutral basis. The government may not have been required to provide the "subsidy" in the first place. But once it has done so, the prohibition against content-based exclusions comes into play. *See, e.g., Perry*, 460 U.S. at 45-46.[8] Congress may no more deny particular advertisers the advertising expense deduction on the basis of their message than it may deny them the use of the mails or require them to pay uniquely high mailing rates.[9]

[8] *Compare Blount* v. *Rizzi*, 400 U.S. 410, 416 (1971) ("'The United States may give up the Post Office when it sees fit, but while it carries it on the use of the mails is almost as much a part of free speech as the right to use our tongues.'") (quoting *United States ex rel. Milwaukee Social Democratic Publishing Co.* v. *Burleson*, 255 U.S. 407, 437 (1921) (Holmes, J., dissenting)).

[9] The Supreme Court's decision in *Buckley* v. *Valeo*, 424 U.S. 1 (1976) (per curiam), confirms this conclusion. The Court in that case sustained Congress's decision to provide more generous funding to major party candidates than to minor party or independent candidates. But the public financing scheme at issue in *Buckley* did not discriminate among parties or candidates on the basis of their views. *See id.* at 95-97.

C. The Government's Purported Interest in "Speaking With One Voice" Cannot Justify the Bradley/Stark Proposals

Senator Bradley also has suggested that deductions for tobacco product advertising expenses should be disallowed because, when it comes to those products, "the Government should speak with one voice"—a voice that, according to Senator Bradley, "should unequivocally say, 'smoking will harm you.' " 133 Cong. Rec. S1616 (daily ed. Feb. 3, 1987). But Senator Bradley overlooks the critical distinction "between governmental promotion of the system of freedom of expression and governmental participation in the system." Emerson, *The Affirmative Side of the First Amendment*, 15 Ga. L. Rev. 795, 799 (1981). In allowing deductions for advertising expenses, the government may be facilitating expression by private groups but it has not stamped that expression with its own imprimatur. It misses the mark to suggest, as Senator Bradley has, that allowing such deductions signals governmental support.[10]

Under Senator Bradley's rationale, the federal government, having chosen to pursue any policy—say, farm price supports or school lunch subsidies—could disallow advertising expense deductions for those opposing that policy. Having chosen to encourage childbirth over abortion through Medicaid reimbursement and other policies, it could deprive pro-choice groups of their tax-exempt status, and then

[10] *See Widmar* v. *Vincent*, 454 U.S. 263, 274 (1981) (public university, in allowing private groups to use campus facilities, "does not confer any imprimatur of state approval" on those groups); *Walz* v. *Tax Commission*, 397 U.S. 664, 675 (1970) (church property-tax exemption is not state "sponsorship" of religion).

disallow deductions by such groups for advertising expenses. Having decided to oppose busing as a remedy for school segregation, it could follow the same course with organizations promoting the use of that remedy. Each of those results is implicit in Senator Bradley's innocuous-sounding defense of his bill. With justifiable irony, ABA President Eugene Thomas has commented: "I don't mind that principle if you let me apply it to all the things I dislike. But if you want to apply it to the things you dislike, then I'm worried." [11]

The Bradley/Stark proposals are, in this connection, altogether different from the legislation upheld

---

[11] Interview, *Advertising Age*, Feb. 23, 1987, p. 80. As noted above, legislation was introduced in the last Congress to ban tax deductions for advertising of alcoholic beverages. In support of that legislation, Representative Brown used the same "subsidy" argument advanced here by Senator Bradley and Representative Stark. He also asserted that "alcohol is America's No. 1 drug problem" (*see* 131 Cong. Rec. E2524 (daily ed. June 4, 1985)), just as Senator Bradley has stated that "[t]obacco is the biggest health hazard facing this country." 133 Cong. Rec. S1616 (daily ed. Feb. 3, 1987).

In the last Congress, Senator Humphrey proposed an amendment to the Internal Revenue Code (S. 2382) to deny tax benefits (exempt status and contribution deductions) to hospitals and other institutions, otherwise tax-exempt, that perform, finance, or provide facilities for abortion. An extraordinarily broad group of distinguished tax lawyers, professors, and former government officials condemned the proposal on the ground that it "runs directly counter to the salutary concept of tax neutrality." Letter to All Senators from Tax Professionals, July 22, 1986. In their view, "federal regulatory intervention through the Internal Revenue Code would be bad for the tax system and contrary to the national interest." Senator Humphrey has reintroduced his bill in the current Congress as S. 264.

by the Supreme Court in *Harris* v. *McRae*, 448 U.S. 297 (1980). There the Court sustained against equal protection challenge Congress's decision to offer reimbursement through Medicaid for childbirth but not abortion expenses. But there was no evidence in *McRae* that Congress was attempting to frustrate the right of women to terminate a pregnancy by abortion. *See id.* at 317 n.19. And regardless of whether the equal protection guarantee limits the government's power to manipulate the exercise of fundamental rights, the requirement that it not regulate *speech* in ways that favor some viewpoints or ideas over others is independently grounded in the First Amendment. The Court's suggestion in *Regan* v. *Taxation with Representation*, 461 U.S. at 548, that it would invalidate a tax discriminating among groups on the basis of their views confirms that its approach in *McRae* is inapplicable where First Amendment rights are at issue.[12]

* * * *

In sum, the means chosen in the Bradley/Stark bills to curtail speech, manipulation of the tax system, does not affect the bills' status under the First Amendment. The protections of the First Amendment do not depend upon the sophistication of the means chosen to accomplish an impermissible result.

---

[12] Three of the dissenters in *McRae* foreshadowed this when they observed:

> "Surely the Government could not provide free transportation to the polling booths only for those citizens who vote for Democratic candidates, even though the failure to provide the same benefit to Republicans 'represents simply a refusal to subsidize certain protected conduct.' " 448 U.S. at 336 n.6 (Brennan, J., joined by Marshall & Blackmun, JJ., dissenting).

II. THE FIRST AMENDMENT LIMITS CONGRESS'S POWER TO BURDEN OR INHIBIT COMMERCIAL SPEECH

Since the Bradley/Stark proposals would trigger First Amendment scrutiny as an attempt to curtail commercial speech, the proposals would be subject to analysis under the Supreme Court's governing test for restrictions on such speech.

A. Development of the Commercial Speech Doctrine

Before 1976, commercial speech was considered by the courts to be outside the ambit of the First Amendment. Then, in *Virginia State Board of Pharmacy* v. *Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748 (1976), the Supreme Court announced a new principle—truthful speech proposing lawful commercial transactions is protected by the First Amendment.[13] Since then, it has applied the principle to invalidate a wide variety of restrictions on commercial speech.[14]

---

[13] Applying the principle in that case, the Supreme Court invalidated a state law forbidding licensed pharmacists to advertise the prices of prescription drugs. This decision was foreshadowed by the Court's holding in *Bigelow* v. *Virginia*, 421 U.S. 809 (1975), that a state may not forbid advertisements announcing the availability of legal abortions.

[14] The Court has invalidated a township ordinance forbidding the posting of "For Sale" and "Sold" signs in residential neighborhoods to stem "white flight" (*Linmark Associates, Inc.* v. *Township of Willingboro*, 431 U.S. 85 (1977)); to strike down a state law banning the advertising and display of contraceptives (*Carey* v. *Population Services International*, 431 U.S. 678 (1977)) and a federal law forbidding the mailing of unsolicited advertisements for contraceptives (*Bolger* v. *Youngs Drug Products*, 463 U.S. 60 (1983)); to invalidate various state-law restrictions on advertising by lawyers

In two cases, the Court has sustained, or indicated that it would sustain, laws that limit the media through which advertisers may promote their products.[15] But in upholding such restrictions, the Court placed great weight on the fact that they applied to *all* speakers, regardless of their message; it was the medium, not the message, that gave offense.[16] In no case since 1976—except in the recent *Posadas* case[17] —has the Court approved a restriction on commercial speech "unless the expression itself was flawed in some way, either because it was deceptive or related to unlawful activity." [18]

Before further discussion of *Posadas*, however, it may be well to understand the two core values that led the Court to extend the First Amendment's protections to commercial speech, and to review the prevailing First Amendment test for restrictions on commercial speech, which *Posadas* reaffirmed.

(*Zauderer* v. *Office of Disciplinary Counsel,* 471 U.S. 626 (1985) ; *In re R.M.J.,* 455 U.S. 191 (1982) ; *Bates* v. *State Bar,* 433 U.S. 350 (1977)) ; and to disapprove a state public service commission regulation banning promotional advertising by electric utilities (*Central Hudson Gas & Electric Co.* v. *PSC,* 447 U.S. 557 (1980)). *See also Lowe* v. *SEC,* 472 U.S. 181, 234-36 (1985) (White, J., joined by Burger, C.J., and Rehnquist, J., concurring) (investment advice newsletter).

[15] *City of Los Angeles* v. *Taxpayers for Vincent,* 466 U.S. 789 (1984) ; *Metromedia, Inc.* v. *City of San Diego,* 453 U.S. 490 (1981).

[16] *Taxpayers for Vincent,* 466 U.S. at 804-05; *Metromedia, Inc.,* 453 U.S. at 505-12.

[17] *Posadas* v. *Tourism Company of Puerto Rico,* 106 S. Ct. 2968 (1986).

[18] *Central Hudson,* 447 U.S. at 566 n.9.

First, we live in a society that does not tolerate information rationing by government—government attempts to manipulate our behavior by curtailing our access to information and ideas.[19] Whether the speech involved is "commercial" or "noncommercial" in nature, the First Amendment condemns paternalistic efforts by government to advance our welfare by keeping us in the dark, shielding us from viewpoints with which it disagrees and from information that it does not like. "It is precisely this kind of choice, between the dangers of suppressing information, and the dangers of its misuse if it is freely available, that the First Amendment makes for us." [20]

Second, "commercial speech serves to inform the public of the availability, nature, and prices of products and services, and thus performs an indispensable role in the allocation of resources in a free enterprise system." [21]

> "So long as we preserve a predominantly free enterprise economy, the allocation of our resources in large measure will be made through numerous private economic decisions. It is a matter of public interest that those decisions, in the aggregate, be intelligent and well informed. To this end, the free flow of commercial information is indispensable." *Virginia State Board of Pharmacy,* 425 U.S. at 765.

---

[19] *Central Hudson,* 447 U.S. at 578 (concurring opinion). *See Linmark,* 431 U.S. at 96; *Carey,* 431 U.S. at 701; *Metromedia,* 453 U.S. at 505; *Bolger,* 463 U.S. at 79 (Rehnquist, J., joined by O'Connor, J., concurring in judgment).

[20] *See Virginia State Board of Pharmacy,* 425 U.S. at 770.

[21] *Bates,* 443 U.S. at 364.

Because these twin values—one political, the other economic—are so fundamental to our system, the Supreme Court has not hesitated to invalidate restrictions on commercial speech even when the asserted justification for the restriction was substantial.[22] *Posadas* indicates that not every commercial speech restriction interfering with these First Amendment values automatically will be invalidated on that basis. But nothing in *Posadas* reasonably can be interpreted as signaling the Court's rejection of those basic values—or as permitting a legislature or reviewing court to ignore them in considering restrictions on speech.

B. The Invalidity of the Bradley/Stark Proposals Under *Central Hudson*

Reaffirming its commitment to the core values that underlie the First Amendment protection afforded commercial speech, the Court in *Central Hudson* articulated a four-part test for assessing the validity of restrictions on such speech:

> "At the outset, we must determine whether the expression is protected by the First Amendment. For commercial speech to come within that provision, it at least must concern lawful activity and not be misleading. Next, we ask whether the asserted governmental interest is substantial. If both inquiries yield positive answers, we must determine whether the regulation directly advances the governmental interest asserted, and whether it is not more extensive than is necessary to serve that interest." 447 U.S. at 566.

It is clear that tobacco product advertising concerns a lawful activity—an activity that has been

---

[22] *E.g., Linmark,* 431 U.S. at 94; *Central Hudson,* 447 U.S. at 571.

lawful throughout the country for many years (unlike casino gambling or prostitution). Likewise, such advertising is not inherently misleading.[23] Thus, tobacco product advertising qualifies for protection under the first prong of the *Central Hudson* test. Assuming for purposes of this discussion (and only for purposes of this discussion) that the Bradley/Stark proposals aim to serve a "substantial" government purpose—the second prong of *Central Hudson* —the proposals still could not survive a First Amendment challenge because they would not satisfy the other two elements of the *Central Hudson* test.

1. *The Proposals Are Unlikely To Achieve Their Stated Purpose*

The suppression of advertising sought by Senator Bradley and Representative Stark would not "directly advance" the asserted governmental interest—curtailing the use of tobacco products.

---

[23] Senator Bradley has suggested that cigarette advertising may be deceptive by virtue of the themes and images it employs (133 Cong. Rec. S1616 (daily ed. Feb. 3, 1987)), but the Tenth and Fifth Circuit Courts of Appeals have rejected a comparable justification for bans on liquor advertising. *Oklahoma Telecasters Association* v. *Crisp,* 699 F.2d 490, 500 & n.9 (10th Cir. 1983), *rev'd on other grounds,* 467 U.S. 691 (1984); *Dunagin* v. *City of Oxford,* 718 F.2d 738, 743 (5th Cir. 1983) (en banc), *cert. denied,* 467 U.S. 1259 (1984). Significantly, the FTC has emphasized that "it is in the public interest to promote the dissemination of truthful information concerning cigarettes which may be material and desired by the consuming public." *FTC Cigarette Advertising Guides,* 4 Trade Reg. Rep. (CCH) ¶ 39,012.70, p. 41,603. Section 5 of the FTC Act, 15 U.S.C. § 45, forbids "false" or "deceptive" commercial acts or practices, and the FTC is empowered to pursue those who violate that prohibition.

The available evidence indicates that advertising expenditures do not significantly affect large, mature consumer markets other than at the brand level. The evidence also shows that tobacco advertising serves primarily as a vehicle for intense interbrand rivalry. The avowed purpose and demonstrated effect of such advertising is to prompt people who already smoke to shift brands, or to remain loyal to the brand being advertised, rather than to attract new smokers.[24] In its 1987 Annual Report to the President, the Council of Economic Advisors stated:

> "There is little evidence that advertising results in additional smoking. As with many products,

---

[24] *E.g.*, M.J. Waterson, *Advertising and Cigarette Consumption* 12-14 (1983). Reviewing the literature in 1971, Judge Skelly Wright stated: "While cigarette advertising is apparently quite effective in inducing brand loyalty, it seems to have little impact on whether people in fact smoke." *Capital Broadcasting Co.* v. *Mitchell,* 333 F. Supp. 582, 588 (D.D.C. 1971) (3-judge court) (dissenting opinion) (footnote omitted), *aff'd mem.*, 405 U.S. 1000 (1972). The Surgeon General, in a 1979 report, agreed that "the major action of cigarette advertising now seems to be to shift brand preferences, to alter market share for a particular brand." *Smoking & Health: A Report of the Surgeon General* 18-23 (1979).

Extensive expert testimony to the same effect was presented in congressional subcommittee hearings in August 1986. *Advertising of Tobacco Products: Hearings before the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce,* 99th Cong., 2d Sess. 640, 708, 666, 811 (1986) ("1986 Hearings") (statements of Dr. J.J. Boddewyn, Dr. Roger D. Blackwell, Dr. Scott Ward, and Michael J. Waterson). *See also Advertising of Tobacco Products: Hearing before the Subcommittee on Transportation, Tourism and Hazardous Materials of the House Comm. on Energy and Commerce,* 100th Cong., 1st Sess. (1987) ("April 1987 Hearing") (statement of Howard H. Bell, President, American Advertising Federation).

> advertising mainly shifts consumers among brands."[25]

In fact, tobacco product consumption actually has increased in most countries in which cigarette advertising has been banned.[26]

---

[25] *Economic Report of the President* 186 (1987).

[26] Waterson, *supra,* at 17-18; Int'l Advertising Ass'n, *Tobacco Advertising Bans and Consumption in 16 Countries* (J. Boddewyn 2d ed. 1986). *See also Economic Report of the President, supra,* at 186 ("Evidence from other countries suggests that banning tobacco advertising has not discouraged smoking."). Noting this fact, FTC Chairman Daniel Oliver has testified in Congress that an advertising ban is unlikely to reduce tobacco consumption. *April 1987 Hearing, supra,* Tr. 15-16. *See also* "FTC Chief Opposes Ad Limits," *Advertising Age,* Nov. 17, 1986, p. 103 (interview with Daniel Oliver). Elizabeth Whelan of the American Council on Science and Health—an outspoken opponent of the tobacco industry—likewise has stated that an advertising ban would "probably not" reduce cigarette consumption in this country. Whelan, "Second Thoughts on a Cigarette-Ad Ban," *Wall St. J.,* Dec. 18, 1985, at 28, col. 6.

Proponents of tobacco product advertising restrictions claim that in both Norway and Sweden there are fewer persons using tobacco now than when those countries allowed tobacco product advertising. But the incidence of smoking among adults overall had begun to decline in Norway *before* advertising was banned in 1975, and stabilized *after* the ban was imposed. In Sweden, cigarette advertising has not been completely banned, and in any event the incidence of smoking among adults also had begun to decline before special restrictions were imposed in 1979. As in Norway, the decline in smoking among adults in Sweden was more pronounced before special advertising restrictions were imposed than afterward. *Tobacco Advertising Bans, supra,* at 22, 28. In 1984, nine years after the advertising ban was imposed in Norway, the proportion of all adult smokers in that country (42 percent) was still more than *one-third higher* than the proportion of all adult smokers in the United States (about 31 percent).

The available evidence also indicates that advertising is not a significant influence on the decision by young people to smoke. Indeed, advertising apparently is one of the least significant factors so far as smoking by teenagers is concerned.[27] A recent five-country study discloses that the incidence of smoking among young people is in fact *higher* in many places where advertising is banned or restricted than where it is not.[28]

---

[27] Waterson, *supra*, at 26-27; *1986 Hearings, supra* (statements of Roger D. Blackwell and Dr. J. J. Boddewyn). Dr. Mortimer B. Lipsett, Director of NIH's National Institute of Child Health and Human Development, testified in 1983 that "[t]he most forceful determinants of smoking are parents, peers, and older siblings." *Smoking Prevention Education Act: Hearings on H.R. 1824 before the Subcomm. on Health and Environment of the House Comm. on Energy and Commerce,* 98th Cong., 1st Sess. 53 (1983). Even Michael Pertschuk, long an advocate of severe cigarette advertising restrictions, told a Harvard seminar in April 1983:

> "No one really pretends that advertising is a major determinant of smoking in this country or any other. * * * Smoking is such a complex form of behavior, and there are so many factors which affect smoking in this society—it is very difficult to isolate any particular one."

Tobacco Issues, Institute of Politics, Harvard University, April 27, 1983, Tr. 8-9.

[28] Int'l Advertising Ass'n, *Why Do Juveniles Start Smoking?* (J. Boddewyn ed. 1986). In Norway, for example, 11 years after a total advertising ban was imposed, the proportion of 7-15 year-olds who smoke regularly (13 percent) was nearly *twice* as high as in Spain (7 percent), where only minor advertising restrictions were in effect, and more than *four times* as high as in Hong Kong (3 percent), where no advertising controls existed. *Id.* at 9. In Norway, 36 percent of all 15 year-olds smoked in 1986, while in Spain the figure was 27 percent and in Hong Kong the figure was 11 percent. *Id.* at 11. *See also 1986 Hearings, supra* (statement of Dr. Boddewyn).

Those responsible for the *Central Hudson* and *Posadas* challenges made no showing that the primary purpose and effect of the advertising in question was to promote competition rather than increase overall demand. They also made no showing that restricting such advertising was not an effective means of dampening demand. It therefore was perhaps reasonable for the majority simply to assume that the utility in *Central Hudson*, and the casino in *Posadas*, would not have challenged the advertising restrictions at issue unless those restrictions served to dampen demand.[29] But tobacco product advertising, like advertising in other mature, adult markets, plays an entirely different role. For the reasons noted, the Bradley/Stark proposals would serve only to impede competition rather than reduce demand. That is not a legitimate governmental purpose that would support severe restrictions on speech.[30]

2. *The Bradley/Stark Proposals Would Not Satisfy the Least Restrictive Means Element of the* Central Hudson *Test*

The Bradley/Stark proposals also would not satisfy the fourth and final prong of the *Central Hudson* test

---

[29] *See Posadas*, 106 S. Ct. at 2977; *Central Hudson*, 447 U.S. at 569.

[30] In May 1986, a federal district court struck down Oklahoma's alcoholic beverage advertising ban under the Equal Protection Clause of the Fourteenth Amendment as an ineffective and therefore irrational means of achieving the state's asserted goals. *Oklahoma Broadcasters Ass'n* v. *Crisp*, No. CIV-81-1756-W (W.D. Okla. May 30, 1986). The Bradley/Stark proposals would suffer the same infirmity.

—that restrictions on commercial speech be no "more extensive than is necessary" to serve the government's asserted interest. Notwithstanding *Posadas*, proponents would be required to defend the Bradley/Stark measures as "narrowly crafted" to serve their asserted purpose, and to establish that their goals could not adequately be served by any less restrictive means.[31] Obviously, restrictions designed to suppress truthful tobacco product advertising by making it inordinately expensive could not be defended as "narrowly crafted" or as the "least restrictive" means of achieving any legitimate governmental purpose. For if a perceived problem can be addressed by providing *more* information, that alternative is by definition less restrictive than an alternative *limiting* communication.[32]

---

tion of all adult smokers in the United States (about 31 percent).

[31] *Zauderer*, 471 U.S. at 644, 647-49, 651-52 n.14; *accord, e.g., Bolger*, 463 U.S. at 80 (Rehnquist, J., joined by O'Connor, J., concurring in judgment); *Lowe*, 472 U.S. at 234-36 (White, J., joined by Burger, C.J., and Rehnquist, J., concurring in result).

[32] *See generally* Note, "The First Amendment and Legislative Bans of Liquor and Cigarette Advertising," 85 Colum. L. Rev. 632 (1985). In case after case, the Supreme Court has emphasized that "the preferred remedy is more disclosure, rather than less." *Bates*, 433 U.S. at 375. Time and again, the Court has applied Justice Brandeis's famous dictum that "the fitting remedy for evil counsels is good ones." *Whitney* v. *California*, 274 U.S. 357, 375 (1927) (concurring opinion joined by Holmes, J.). *See Virginia State Board of Pharmacy*, 425 U.S. at 771 n.24; *Zauderer*, 471 U.S. at 650-52; *Central Hudson*, 447 U.S. at 570-71; *Linmark*, 431 U.S. at 97.

For this reason, the denial of tax deductions for tobacco product advertising expenses, judged by the Supreme Court's long-established commercial speech doctrine, would fail the fourth prong of the *Central Hudson* test. The proposed denial of tax deductions would fail this prong of the *Central Hudson* test even if it did not result in eliminating such advertising altogether. For the test of a proposed restriction on commercial speech is not whether it is less restrictive than some more drastic measure but whether it is less restrictive than other approaches that would address its sponsors' concerns through increased information.[83]

---

[83] Indeed, four Justices have expressed the view that if "more speech" cannot curtail demand for or use of a product the goverment's only recourse is to attack the perceived problem openly and directly—by forbidding or restricting use of the product—not by coerced silence. *See Central Hudson*, 447 U.S. at 573-79 (Blackmun, J., joined by Brennan, J., concurring in judgment); *id.* at 581 (Stevens, J., joined by Brennan, J., concurring in judgment); *Posadas*, 106 S. Ct. at 2980 (Brennan, J., joined by Marshall & Blackmun, JJ., dissenting).

Recently enacted federal legislation already requires cigarette advertising to carry four rotating health messages. This legislation also directs the Secretary of Health and Human Services to establish and carry out a broad program to educate the public with respect to "any dangers to human health presented by cigarette smoking." Comprehensive Smoking Education Act, Pub. L. No. 98-474, § 3(a), 98 Stat. 2200 (1984) (codified at 15 U.S.C. § 1341(a)). Similar legislation has been enacted, even more recently, for smokeless tobacco products. Comprehensive Smokeless Tobacco Health Education Act, Pub. L. No. 99-252, § 2(a), 100 Stat. 30 (1986) (codified at 15 U.S.C. § 4401(a)). The Bradley/Stark proposals seem particularly ironic and ill-timed in view of this recent action by Congress.

The Supreme Court has yet to define the precise extent of the government's authority to require advertising to include

C. The Significance of *Posadas*

In the light of this discussion, it should be apparent that Justice Rehnquist's opinion for the 5-4 majority in *Posadas* is unlikely to provide a basis for sustaining the Bradley/Stark cigarette advertising proposals. The *Posadas* decision cannot be understood clearly, or be reconciled with the Supreme Court's other commercial speech decisions, without appreciating its significance as a case from Puerto Rico—a jurisdiction with a "unique cultural and legal history" (106 S. Ct. at 2976 n.6) and a politically delicate relationship between Puerto Rico and the United States. As Hector Reichard, Jr., a former Attorney General of Puerto Rico, has observed, "the Supreme Court often says that it applies the same constitutional principles to us as it does to Congress and the States. But in reality it is far more reluctant to interfere in our affairs." [84]

Specifically, the Court in *Posadas* was confronted with a situation in which Puerto Rico, whose economy depends heavily on tourist dollars, had elected to stimulate this source of revenue by legalizing an activity that had long been illegal—casino gambling. But it did not want to encourage its own citizens to engage in that "sophisticated" activity. 106 S. Ct. at 2977 (quoting Superior Court opinion). Had economic circumstances not required Puerto Rico to try to attract tourists by making casino gambling legal, it is

---

warnings or disclosures but it has made clear that some disclosure requirements may be impermissible. *Zauderer,* 471 U.S. at 651. *Cf. PG&E* v. *PUC,* 106 S. Ct. 903 (1986) (requirement that utility include messages of its adversaries in its monthly billing envelopes violates the First Amendment).

[84] Statement to the ABA House of Delegates on behalf of the Joint ABA/ANPA Task Force, Feb. 16, 1987, p. 3.

unlikely that it would have decriminalized the activity at all. The *Posadas* majority was understandably reluctant to upset this arrangement. To suppose that a majority of the Court would harbor a comparable reluctance when reviewing legislation designed to suppress speech throughout the United States is to sever *Posadas* from its essential moorings.[35]

Moreover, the advertising restrictions at issue in *Posadas* were restrictions in name only. Since the restrictions focused on the audience to whom casino-gambling advertisements were "addressed," and not the audience they reached, the Court in *Posadas* was not in fact faced with advertising controls that, if approved, actually would keep people in ignorance.[36] The illustory quality of the *Posadas* restrictions undoubtedly goes far to explain the majority's readiness to defer to Puerto Rico's judgment as to the appropri-

[35] The majority's special reluctance to interfere in Puerto Rico's affairs is illustrated both by its pointed reference to Puerto Rico's "unique cultural and legal history" (106 S. Ct. at 2976 n.6) and by its willingness to accept Puerto Rico's assertion that there was no inconsistency in the Commonwealth's decision to allow advertising for horse-racing, cockfighting, small games of chance at *fiestas*, and the lottery—while forbidding casino-gambling advertising. Puerto Rico justified this anomalous posture on the ground that those less "sophisticated" forms of gambling "have been traditionally part of the Puerto Rican's roots." 106 S. Ct. at 2977 (quoting Superior Court opinion). It is scarcely conceivable that the *Posadas* majority would have accepted such a patronizing assertion from New Jersey or Nevada—or from Congress.

[36] Counsel for Puerto Rico stated during oral argument in the Supreme Court that casino advertising in a Spanish-language daily with 99-percent local circulation would be permitted so long as the advertising "is addressed to tourists and not to residents." Oral Arg. Tr. 26.

ateness of those restrictions. Because the *Posadas* restrictions by their nature could not manipulate consumer behavior by suppressing information, that aspect of the majority's opinion in *Posadas* represents at bottom a brand of dicta—unusual dicta but dicta nonetheless.

Finally, as discussed above, there was no showing in *Posadas* that casino gambling advertising addressed to Puerto Ricans would serve any function except to stimulate overall gambling activity. It was not argued that such advertising simply constitutes a means by which one casino seeks to attract customers from other casinos and keep its existing patrons loyal. In such circumstances it was perhaps understandable for the *Posadas* majority to assume that the casino in that case would not have litigated the case "all the way" to the Supreme Court (106 S. Ct. at 2977) unless the advertising restrictions in question would operate to reduce demand—and to assume that the Puerto Rico Legislature, in enacting the restrictions, shared this view. The Court in *Posadas* did not face a record—as it would in the case of tobacco product advertising—demonstrating that the advertising at issue served primarily as a vehicle for competition rather than to promote demand.[87]

---

[87] In sustaining the casino-gambling advertising restrictions, the *Posadas* majority pointed to other limited advertising restrictions, including the ban on cigarette advertising in the electronic media. 106 S. Ct. at 2980 n.10. Justice Rehnquist cited these other limited restrictions to illustrate his suggestion that a legislature may curb advertising of products or services whose sale it could prohibit. However, this suggestion was *dicta,* unnecessary to the holding in the case. *See* Congressional Research Service, "The Proposed

Professor Philip B. Kurland of the University of Chicago Law School has cautioned that *Posadas* should not be relied upon because its reasoning, if taken at face value, "is so inconsistent with everything that has gone before."[38] His caution is well-founded. If one interprets the narrow majority opinion in *Posadas* as deciding that the government has virtually unlimited power to suppress truthful speech concerning lawful products and services as long as there is no constitutionally protected right to purchase the products or services themselves, then almost all of the Court's commercial speech decisions since 1976 would now be open to reconsideration. Such analysis would militate in favor of sustaining, not invalidating, the advertising restrictions at issue in those cases, since the underlying activity in most of the cases was not constitutionally protected.

As Assistant Attorney General Charles J. Cooper has noted, "it is unusual for the Court to effect such

---

Prohibition on Advertising Tobacco Products: A Constitutional Analysis," pp. 15-16, 19 (Dec. 30, 1986). Moreover, the suggestion has been widely criticized as untenable by the most eminent constitutional scholars. *E.g., N.Y. Times*, Feb. 22, 1987, § E, p. 9 (interview with Professor Philip B. Kurland); Professor William Van Alstyne, letter dated Jan. 25, 1987, to Eugene Thomas, ABA President, and ABA Board of Governors. Justice Rehnquist also cited the cigarette advertising ban in the electronic media as an example of a case in which the legislature had "conclude[d]" that *more speech* would not curtail consumption of a controversial product or service. 106 S. Ct. at 2978. As discussed above, however, the available evidence, gathered in the 17 years since Congress banned cigarette advertising from the electronic media, demonstrates that *bans* do not curtail consumption of tobacco products.

[38] Interview, *N.Y. Times*, Feb. 22, 1987, § E, p. 9.

a dramatic break with precedent without some explanation."[39] The Court in *Posadas* did not purport to overrule its prior cases in the area. To the contrary, the majority expressly reaffirmed the *Central Hudson* principles, which assure protection of the basic values that led the Court to extend the First Amendment's guarantees to commercial speech in 1976. Absent a clear statement from the Court that *Central Hudson* is no longer good law, the majority opinion in *Posadas* must be viewed in the sensitive and special context presented by Puerto Rico's casino-gambling advertising restrictions. As Justice Rehnquist himself stated in an analogous context:

> "Since the court saves harmless from its present opinion our prior cases in this area, * * * it may be fairly inferred that it does not intend the results which might otherwise come from a literal reading of its opinion." *Bigelow*, 421 U.S. at 836 (dissenting opinion).

* * * *

In sum, the Bradley/Stark proposals would constitute a forbidden attempt by government, through manipulation of the tax code, to influence consumer choice by restricting the flow of truthful information about lawful products, irrationally impeding the in-

---

[39] Letter from Charles J. Cooper, Assistant Attorney General, Office of Legal Counsel, Feb. 9, 1987, to Henry G. Miller, Past President, New York State Bar Association, p. 1. For this reason, the Justice Department also has counseled against relying on *Posadas* to support a tobacco product advertising ban. The Court sometimes may chip away at its precedents but when the Court intends to effect a wholesale revision of its constitutional jurisprudence it says so expressly. *See, e.g., Garcia* v. *San Antonio Metropolitan Transit Authority,* 469 U.S. 528 (1985).

telligent exercise of consumer choice. The proposals also would likely be held to fail the literal terms of the four-part *Central Hudson* test, for it could not be shown that the proposals would directly and effectively serve the government's asserted interest or would do so in the least restrictive way.

COVINGTON & BURLING

STATEMENT OF LARRY C. HOLCOMB

Mr. Chairman and members of the Committee. My name is Larry Holcomb. I am a principal in Holcomb Environmental Services, serving as a consultant in the field of environmental toxicology. I have been asked by The Tobacco Institute to present my views on one of the issues being addressed by this Committee: whether scientific evidence has established that exposure to environmental tobacco smoke (ETS) causes respiratory problems in children. The views I express are mine alone. My statement and my answers to your questions should not be interpreted as representing tobacco industry views. I am speaking as a scientist representing my own evaluation of the relevant scientific literature.

As I will explain, there are a number of open questions about the possible relationships between ETS exposure and children's respiratory disease. In my view, considerable scientific work would need to be performed before we could conclude that a cause-and-effect relationship has been shown in this area.

By way of background, I hold a Ph.D. in Zoology from Michigan State University, where I recently taught a course in hazardous materials risk assessment. As an independent consultant in environmental toxicology, I often am asked to review and comment on toxicological issues. These issues include the health impact of exposure to chemicals associated with toxic waste sites, air and water pollution, and occupational exposures. From 1981-1986 I served as Executive Secretary of the Michigan Toxic Substance Control Commission. One of the greatest challenges of that position was to determine whether a toxic substance issue was a real problem that needed attention. It was my responsibility to determine the scientific validity of evidence that was presented and then make recommendations based on an evaluation of the strength of the pertinent data.

INTRODUCTION

A number of studies have been performed to investigate the possible impact of ETS on the respiratory health of children. The examination of any potential health problem no matter how provocative or politically controversial, should involve, of course, the use of standard scientific methodology. The situation in that regard is no different for ETS than it would be for any other chemical compound] or mixture of compounds.

This presentation will review the available scientific literature on whether exposure to ETS increases the risk of respiratory problems in children. In the past, several approaches to health questions involving ETS have been considered, namely, (1) extrapolation from data obtained in studies of active smoking, (2) animal toxicologic studies and (3) epidemiologic data. As suggested in the 1986 report of the National Research Council of the National Academy of Sciences (NRC/NAS), extrapolation from studies of active smoking is not appropriate since ETS exposure and active smoking (*i.e.*, inhalation of mainstream smoke) present significantly different situations. ETS is a mixture of sidestream smoke (emitted from the tip of the cigarette) and exhaled mainstream smoke, and it is a mixture that has been aged and markedly diluted in the indoor air. ETS and mainstream smoke differ chemically and physically, as reflected, for example, in their respective pHs, particle size and the distribution of their constituents among gaseous and particulate phases. Furthermore, unlike active smoking, ETS exposure is through the nose with shallow breathing.

Consistent with these fundamental differences between active smoking and ETS exposure, levels of specific tobacco smoke markers (such as nicotine or its metabolite, cotinine) in body fluids of ETS-exposed individuals are usually very small (1% or less) relative to those of active smokers. Additionally, to my knowledge no toxicologic study in animals to date has adequately addressed the possible health effects of ETS, since these studies have involved extremely high doses, usually of mainstream smoke. Therefore, the only relevant information that is available on the possible effects of ETS on the respiratory system in children comes from epidemiologic studies.

EPIDEMIOLOGIC STUDIES

In epidemiologic studies, information about family health and smoking history has been obtained from supervised or unsupervised questionnaires, usually completed by parents or guardians. The end-points of these studies have been (1) the incidence of respiratory symptoms and disease and/or (2) pulmonary performance, as measured by respiratory flow rates. The incidence of respiratory symptoms or illness and pulmonary function data have been compared statistically in children classified as to ETS exposure by their parents' smoking status, with the statistical significance of an association having been regarded as suggesting a link between parental smoking and an adverse respiratory health effect in children. In all of the relevant epidemiologic reports it has been assumed that parental smoking (or the smoking of other household smokers) is an adequate surrogate for ETS exposure of the children being examined. Despite the dubious nature of that assumption, in none of the studies has ETS exposure been verified by measurement of a specific environmental or biological marker, such as airborne nicotine or body fluid cotinine.

The epidemiologic literature pertaining to the possible effects of ETS on children was recently examined at an international symposium on ETS issues at McGill University in Montreal, in which I participated. (Witorsch, 1990; copy of proceedings attached for reference). That examination pointed out that age differences were apparent in the literature on the relationship between parental (or household) smoking and respiratory effects in children. A number of epidemiologic studies have reported an association between parental, usually maternal, smoking and increased risk of respiratory problems (such as cough, wheezing, asthma, bronchitis and pneumonia) in infants and children under five years of age. A few of these studies also have reported that the effects varied dose-dependently with the amount of ETS exposure (*e.g.*, number of cigarettes reportedly smoked by the parents and/or number of smokers).

The literature on the reported statistical association between parental smoking and respiratory effects is not consistent in children five years and older. An examination of 28 studies at the McGill symposium revealed eight giving negative results. In those reporting a statistical association, the relative risk was usually below 2.0 and the results were highly variable. When a particular statistical association was reported (such as with asthma, coughing, sneezing and bronchitis), there was considerable variation from one study to the next. A particular symptom or illness was confirmed usually no more than about 50 percent of the time.

As with respiratory symptoms and illness data, the reported statistical association between parental smoking and pulmonary function in older children is also inconsistent. (I might note here that such studies are difficult to undertake in young children.) For example, a decrement was observed for respiratory flow rates (*e.g.*, the FEV_1 or the volume of air forcibly expired in 1 second) in only 12 of 23 studies. Furthermore, the decrements observed were usually small in magnitude (*e.g.*, <1% to 7% for FEV_1) and pulmonary function was still within the normal range. Of five studies that have attempted to associate parental smoking with lung growth in children (measured as a change in FEV_1 over time) only two have reported a small decrement (1% or less per year). When studies have been published on the same cohort of children at different times, the data of one study have not been confirmed by the data of the subsequent study.

The notion of age-dependency suggested in the available epidemiologic literature was noted in the 1986 Reports of both the U.S. Surgeon General and the National Research Council of the National Academy of Sciences. Several studies have reported that as the child ages (*e.g.*, reaches 6 months to 2 years) the association between parental smoking and respiratory effects diminishes or even disappears (Colley *et al.*, 1974; Fergusson *et al.*, 1981; Fergusson and Horwood, 1985; Chen *et al.*, 1988).

The apparent age-dependent association could reflect a declining sensitivity to ETS as the child ages and/or a change in the child's relationship with the mother. As noted above, parental smoking has served as the surrogate for ETS exposure in the relevant studies without verification with a specific marker. While some studies (not involving health effects) report a correlation in body fluid cotinine levels in

children with the number of smokers in the family and other parameters of household smoking, the issue of whether parental smoking necessarily implies an effect of ETS, or whether other factors also correlated with parental smoking could be involved, remains to be determined.

It is important to understand that no epidemiologic study establishes a cause and effect relationship—that is, that ETS exposure *actually causes* respiratory problems in children. Instead, results are expressed as a statistical association or computation of relative risk between an exposed population and a population that has not been exposed. This uncertainty between epidemiologic associations and cause and effect is due to the fact that numerous variables or confounding factors, many difficult to control, can influence the outcome of an epidemiologic study.

The apparent association between parental smoking and respiratory health in young children could reflect various sources of bias, most notably those related to socioeconomic status. Parental smoking has been shown to be more prevalent in low income families and positively correlated with factors that may impair respiratory health, such as outdoor air pollution, cross-infection, gas stove usage, more family members per living space, and frequent change of address (Kerigan *et al.*, 1986). The data of Harlap and Davies (1974) illustrate how socioeconomic status or related factors could confound an effect attributable to parental smoking. These researchers reported that, while parental smoking was associated with increased respiratory illness in infants, it also was associated with increased hospitalizations of infants due to injury and poisonings.

Adjustment for socioeconomic status in epidemiologic studies involves consideration of maternal education, income, occupation and ethnicity, among other factors (Green, 1970). Most relevant studies to date have either ignored socioeconomic factors or have underestimated their impact and complexity. Finally, even the most stringent of socioeconomic adjustments may not adequately correct for such important factors as family attitudes and practices concerning fitness, stress management, and prenatal and childhood care and nutrition.

I note, finally, that Rubin and Damus (1988) recently evaluated 30 studies dealing with ETS exposure and respiratory health and function in children. These papers were quantitatively rated on the basis of seven important epidemiologic criteria (such as data collection, estimates of smoke exposure, definition of illness). The authors concluded that most of the studies reviewed had significant design flaws that compromised reliance on their conclusions.

SUMMARY AND CONCLUSIONS

An association between parental (usually maternal) smoking and increased incidence of respiratory symptoms and disease in young children (0-5 years) has been reported in a number of epidemiologic studies. However, the statistical association reported frequently is not significant, and the study designs and protocols do not permit a study-to-study comparison. The observed association may well be due to socioeconomic factors and/or related confounding variables. As far as older children (5+ years) are concerned, the data relating ETS exposure from parents to impaired respiratory health and pulmonary function are inconsistent and thus inconclusive.

With regard to both younger and older children, further work would be needed before one could reach a definitive conclusion about the possible effects of ETS. Worthwhile future projects would include animal toxicologic studies, epidemiologic studies employing standardized questionnaires and other more reliable techniques to minimize problems of misclassifications and confounding, and studies using actual measurements of ETS exposure in children by means of reliable environmental and biological markers rather than parental smoking as a surrogate measure.

Mr. Chairman, that concludes my statement. I will be happy to answer any questions.

REFERENCES

Chen, Y, Li, W, Yu, S, Qian, W, Chang-Ning epidemiological study of children's health: I: Passive smoking and children's respiratory diseases. Int. J. Epidemiol. 17: 348-355, 1988.

Colley, JrT, Holland, WW, Corkhill, RT. Influence of passive smoking and parental phlegm on pneumonia and bronchitis in early childhood. Lancet 2: 1031-1034, 1974.

Committee on Passive Smoking, Board on Environmental Studies and Toxicology, National Research Council. Environmental Tobacco Smoke: Measuring Exposure and Assessing Health Effects, National Academy Press, 1986.

Fergusson, DM, Horwood, LJ, Parental smoking and respiratory illness during early childhood: A six year longitudinal study. Pediatric Pulmonology, I: 99-106, 1985.
Fergusson, DM, Horwood, LJ, Shannon, FT, Taylor, B, Parental smoking and lower respiratory illness in the first three years of life, J. Epidemiol. Comm. Health 35: 180-184, 1981.
Green, LW, Manual for scoring socioeconomic status for research on health behavior. Public Health Reports 85: 815-827, 1970.
Harlap, S, Davies, AM, Infant admissions to hospital and maternal smoking. Lancet I: 529-532, 1974.
Kerigan, AT, Goldsmith, CH, Pengelly, Lb, A three-year cohort study of the role of environmental factors in the respiratory health of children in Hamilton, Ontario. Am. Rev. Respir. Dis. 133: 987-993, 1986.
Rubin, DH, Damus, K, The relationship between passive smoking and child health: Methodologic criteria applied to prior studies, The Yale J. Biol. Med. 61: 401-411, 1988.
Surgeon General, U.S. Department of Health and Human Services, Public Health Services. The Health Consequences of Involuntary Smoking: A Report of the Surgeon General. U.S. Government Printing Office, 1986.
Witorsch, RJ, Parental smoking and respiratory health and pulmonary function in children: A review of the literature and suggestions for future research. In: Environmental Tobacco Smoke: Proceedings of the International Symposium at McGill University, Ecobichon, D.J. and Wu, J.M., (eds.). Lexington Books, D.C. Heath, Lexington MA., pp. 205-226; 1990

Statement of Jolly Ann Davidson, National Spokesperson, The Tobacco Institute's Responsible Living Program

I am Jolly Ann Davidson, National Spokesperson for The Tobacco Institute's Responsible Living Program, and I appreciate the opportunity to share with you a brief overview of our program. I am a former teacher and have been involved with the governance of education at the state and national levels for a number of years. The Tobacco Institute shares your concern over the sale of tobacco products to minors. Prevention of sales to minors is critical. Equally important is communication and understanding within the family, discouraging young people from ever trying to make a purchase.

Our Responsible Living Program reaches out to families because we believe strongly that parents are in the best position to influence the behavior of children. The program embraces the concept that we must all work together—communities, businesses, schools, and parents—to assist our young people in becoming responsible adults. This concept of working together is paramount in preventing the sale of tobacco products to youngsters.

The Responsible Living Program was developed to encourage greater communication between parents and children, in order to teach young people how to make sound decisions when it comes to many issues, all too often inappropriately influenced by peer pressure—drugs, sex, smoking, and alcohol, to name just a few.

The Tobacco Institute does not want our young people to smoke. So far as The Institute is concerned smoking is for those adults who choose to smoke. As a way to address the need for greater parental influence, The Institute published "Helping Youth Decide" and "Helping Youth Say No"—easy to read booklets that offer insight and guidelines to help parents and their children to better communicate. The booklets are available free of charge.

"Helping Youth Decide," published in 1984, is divided into three parts. Part one discusses what's involved for parent and child during those adolescents years. Part two focuses on ways to help—how to listen so youngsters will talk and how to talk so youngsters will listen—techniques to use—and tips to avoid communication barriers. Also included are the actual steps involved in making a sound decision. The third part of "Helping Youth Decide" offers materials designed to help parents implement the ideas presented. A unique feature is a questionnaire for parents and youths to take independently and then compare. The questions are identical. However, the answers given, far too often, differ greatly. It's a good starting point and a terrific way to foster good family communication.

The booklet, "Helping Youth Say No," focuses on the various ways peer pressure can work, in ways both obvious and subtle, to bring about unsound decision-making. It suggests ways in which parents can build self-confidence in their youngsters and offers pointers on how one copes with/resists peer pressure. "Helping Youth Say No" does just what the title states. The booklet also discusses how we can best say

no to our children and yet still enhance family communication. The final portion of the booklet is comprised of activities for parents and teens to engage in together.

Over 700,000 copies of the two booklets have been distributed—requests coming in from every state, from Puerto Rico, Guam and the virgin Islands—as well as Canada and five overseas countries. We've had thousands of letters of grateful appreciation from parents, guidance counselors, PTA's, educators, ministers, social workers, psychologists, and from teens themselves. Like the 13-year-old girl from Missouri who wrote about "Helping Youth Decide": "I cannot begin to tell you how much it helped. My father and I are much closer than we ever were. I've referred you to many of my friends. There are more teens out there that need help, than you think. Once again, I thank you and my father thanks you." The booklets have also won awards and letters of commendation from educational organizations, legislators, governors, and members of Congress.

Using the booklets as a core, the third aspect of the Responsible Living Program was developed—the Community Alliance Program. Twenty-two communities across the United States have received grants to be used to promote effective and healthy family relationships and to deal with the difficult issues our young people are facing. The program has been used by communities to heighten public awareness and unite schools and communities in helping families. The individual projects vary in scope and subject matter, focusing on the needs of the community. The programs employ workshops and speakers with broad based support and participation. Two examples: Fargo, North Dakota, sponsored a workshop attended by four hundred parents. It featured a keynote address by Keith Nord, former Minnesota Viking, and was followed by seventeen mini-sessions on a variety of topics—one of which was "Teaching Abuse Prevention."

The CAP at Walt Whitman High School in Bethesda, Maryland, included in their activities an assembly regarding drug abuse and a visit by ninth graders to the local drug shock trauma unit.

Although funding was provided on a one-year basis to Community Alliance Programs, I am pleased to report that most programs have been institutionalized. All twenty-two communities devised programs that are success stories!

The Tobacco Institute takes great pride in the Responsible Living Program, and I feel most fortunate to be involved as its spokesperson. We feel we are reaching out to parents and young people and making a difference in the lives of American families. Open discussion and joint decision-making between a parent and child on a topic, such as the purchase of tobacco products, is without question the best prevention. Again, my thanks for the opportunity to testify.

Statement of James A. Will

Mr. Chairman and members of the Committee, my name is James A. Will. I am a professor at the University of Wisconsin. I have been asked by The Tobacco Institute to present my views on one of the issues that the Committee is considering: whether it has been established by scientific data that environmental tobacco smoke (ETS) causes respiratory problems in children. The views I express are mine alone, however, and are not representative of any institution.

I hold a Ph.D. in comparative cardiology and my expertise is in cardiopulmonary physiology, pharmacology, and morphology. In that context, I have studied the lung and disease which affects the lung using animals as models for human disease as well as studying human subjects themselves. As a consultant to the pharmaceutical industry, I have been involved in the development of protocols and the review of the results of human studies. I hold appointments in the Department of Anesthesiology in the University of Wisconsin Medical School and in the Department of Veterinary Science. I am also a Director of an administrative unit of the Graduate School. I have been a reviewer of scientific manuscripts for many professional journals and grant applications for U.S. governmental, international, and private granting agencies.

I am interested in this issue from the standpoint of scientific credibility. The question I address is, what data are there to support the hypothesis that ETS causes disease, particularly in children? I am especially interested in the existence of other confounding elements which can bias our interpretation of data which are controversial and often equivocal. It is important that this issue not be confused with smoking per se; these issues are entirely separate.

Recently, questions have arisen concerning scientific fraud and scientific integrity in original research. It is important that we also maintain scientific integrity in our interpretation of the results of others work. In most cases, critical reviews prior to

publication set definitive limits on the interpretation of the results by the scientist/author based upon the data presented. After the scientists themselves have limited the interpretation of their own experiments and the statistics they have used to come to their conclusions, it is scientifically questionable when others attribute more or less significance to that work based on personal biases.

Scientific interpretation of data involves the application of specific criteria to demonstrate whether the hypothesis proposed has been adequately tested and whether the data support or reject the hypothesis.

If we apply these principles to the current scientific literature on health effects of ETS, we find it is impossible to conclude that ETS causes respiratory disease in children or adults. This review will be limited to the putative effects of ETS on the respiratory system of children.

Some of the most important published data have sought to understand the broad picture, i.e., not only the possible influence of ETS, but many of the environmental influences of the world that a child lives in. One of the latest of these publications examines the possible effects and interactions of a number of environmental factors on 7,200 North American persons; 1,357 of these were children (729 boys and 628 girls) (Hosein, Corey, and Robertson 1989). In addition to the number of smokers in the household, the heating system (hot water, hot air, or radiant electric), presence of gas appliances, presence of pets, hobbies involving the use of glue, paint or wood dust, the use of air conditioning or humidification, and the concentration of people (number of persons living in the home) were recorded.

These investigators used a survey typical of epidemiologic investigations and a pulmonary function test to get their results. In summary, what they found was as follows: (1) No significant or consistent effects were reported on pulmonary function from the presence of smokers in the home. (2) On the other hand, there was a more marked effect on pulmonary function in both sexes from the use of gas stoves, hot water heating systems, and the lack of air conditioning. (3) Hobbies, the presence of fireplaces, and an increased household population were related to pulmonary function decrements in boys but not in girls.

This study shows that, had the other environmental factors not been considered and statistically evaluated, ETS might have been falsely implicated in the decrement in pulmonary function and increased symptoms shown in some of these children. Confounding factors, then, are critically important to consider when evaluating studies done on ETS.

Previous studies by othe s reported similar results looking at similar environmental factors other than smoking or different confounding factors such as socioeconomic status (Kerigan et al. 1986; Harlap and Davies 1974). In each case, the confounding factors were reported to have a notable relationship with measures of respiratory effects. When considering these confounding factors that are measurable, other factors that either have not been measured or are very difficult to measure are not included in the presently available literature. Questions that arise are:

(1) Are parents who smoke likely to have other lifestyle differences, *i.e.*, are they less health conscious?

(2) Are there dietary differences that may predispose to respiratory disease either directly or by a decreased immune response to infective agents?

(3) Are children of a lower socioeconomic status exposed to higher environmental stress?

(4) Are children of parents who both work more likely to have respiratory disease due to the contact with many more children in a day care center?

(5) Does the outdoor environment have an influence on the indoor environment?

Very little data are available to answer these questions, even though these factors may be important. One study that may have some bearing on nutritional status and the effects of ETS comes to the conclusion that diet may have an important influence (Hirayama 1984). In this study, the risk reported for cancer in a Japanese household where smokers lived was less for those individuals who had an adequate intake of green-yellow vegetables. This is probably a food group minimally included in the diet of those in a lower socioeconomic status.

Harlap and Davies studied 10,672 infants from birth to one year of age and reported that family socioeconomic status was probably the most important factor that predisposed to episodes of bronchitis and pneumonia. Regardless of ETS, the incidence of bronchitic or pneumonic episodes for the highest socioeconomic group of infants was one-third to one-quarter of the incidence associated with the medium or lowest socioeconomic groups. There was no significant increase in upper-respiratory-tract infections in the presence of a smoking mother.

Finally, socioeconomic status seems important with regard to outdoor pollution as a background environmental factor and a correlate to the incident of smokers. Ker-

rigan et al., for example, found that the incidence of smoking parents was higher in the industrial areas they studied, and this area had the highest outdoor particulate pollution rate as well (Kerrigen et al. 1986).

It seems obvious that the determination of whether ETS is an important factor in respiratory illness in children is complex and not easily measured. Furthermore, there are reports that other environmental factors may be important in predisposing children to infant and childhood respiratory disease. Finally, it would be a difficult task to regulate legislatively the exposure of children to ETS; however, many other, undeniably important environmental factors could be changed through reduction of air pollution, improvement of living conditions, and programs to improve socioeconomic conditions.

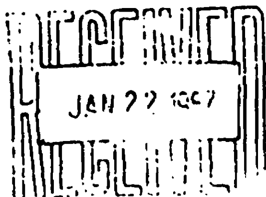
REFERENCES

1. Harlap, S. and A.M. Davies. Infant admissions to hospital and maternal smoking. Lancet 1, pp. 529-532, 1974.
2. Hosein, H.R., P. Corey, and J. MC. D., Robertson. The effect of domestic factors on respiratory symptoms and FEV_1. Int. J. Epidemiol. 18:2, pp. 390-396, 1989.
3. Kerigan, A.T., C.H. Goldsmith, and D. Pengelly. A three-year cohort study of the role of environmental factors in the respiratory health of children in Hamilton, Ontario. Am. Rev. Respir. Dis. 133, pp. 987-993, 1986.
4. Hirayama, T. Lung Cancer in Japan: Effects of nutrition and passive smoking. In: *Lung Cancer: Causes and Prevention*. VCH Publications. pp. 175-195, 1984.

Enclosure 1.

NCHS Advancedata Number 113 November 15, 1985 - See pp. 5,7,8.

From Vital and Health Statistics of the National Center for Health Statistics — Number 113 • November 15, 1985



NOTICE
This material may be protected by copyright law (Title 17 U.S. Code).

Provisional Data from the Health Promotion and Disease Prevention Supplement to the National Health Interview Survey: United States, January–March 1985

The National Center for Health Statistics included a special supplement on health promotion and disease prevention as part of the 1985 National Health Interview Survey questionnaire. This report presents provisional findings from the first three months of data collection with that supplement.

The 1985 Health Promotion and Disease Prevention Supplement is designed to monitor progress toward one of the major initiatives of the Department of Health and Human Services. This initiative is described in the 1979 Surgeon General's Report on Health Promotion and Disease Prevention, *Healthy People.*[1] In that report, broad goals were established for the improvement of the health of Americans. The 1980 Public Health Service report, *Promoting Health/Preventing Disease: Objectives for the Nation,*[2] details specific objectives necessary for attainment of those goals in each of fifteen priority areas. The target date for achieving the objectives is 1990. This 1985 supplement will be used for data collection again in 1990 for the purpose of monitoring progress achieved in the intervening five years.

The 1985 Health Promotion and Disease Prevention Supplement is devoted primarily to the collection of baseline data on the following topics: general health (including nutrition), injury control and child health, high blood pressure, stress, exercise, smoking, alcohol use, dental care, and occupational safety and health. Those topics were selected after consultation with the Office of Disease Prevention and Health Promotion (Assistant Secretary for Health) as well as with the agencies designated by the Assistant Secretary for Health as having "lead" responsibility for implementing and monitoring progress toward achieving the 1990 objectives. Within each agency, subject matter experts also were consulted during the development of the questionnaire for the supplement.

This report presents provisional data, based on the first quarter of data collection, for selected items in the supplement. In most cases, the actual question asked of the respondent is shown on the table along with the response categories. In a few cases, there has been minor paraphrasing or combining of questions. Each question is referenced to the actual item number on the questionnaire.

In general, the items in the supplement are of the following two types: those related to individual health behaviors and those related to knowledge of health practices. Most of the questions on knowledge of health practices have answers that are currently presumed to be correct and are indicated in bold type in table 1. For some questions, references are provided for selected publications that present related data from previous data collection by the National Center for Health Statistics.

Estimated percents or percentage distributions are presented (table 1) for all persons 18 years of age and over and for four age groups and both sexes. Generally, except for the questions on knowledge of health practices where "don't know" is a legitimate response, "don't know" and other inappropriate responses were excluded from the denominator in the calculation of the estimates. The estimated population for each of the demographic categories is shown in table 1 to allow readers to derive a provisional estimate of the number of people in the United States with a given characteristic. However, the estimates presented in this report are provisional and will differ to some degree from estimates made using the final data file for the following reasons: (a) this report is based on data collected

[1]Office of the Assistant Secretary for Health and Surgeon General. *Healthy People—The Surgeon General's Report on Health Promotion and Disease Prevention—Background Papers 1979.* DHEW Pub. No. (PHS) 79-55071A.
[2]U.S. Department of Health and Human Services, Public Health Service. *Promoting Health/Preventing Disease: Objectives for the Nation.* Washington: U.S. Government Printing Office, 1980.

BEST AVAILABLE COPY

during the first three months of 1985 rather than the entire calendar year and those items affected by seasonality (exercise, for example) are subject to significant change; (*b*) the data file was edited internally, but it was not edited with respect to the National Health Interview Survey (NHIS) core demographic variables (such as age, sex, and employment status); (*c*) the simplified weighting procedure used was not adjusted to all factors normally used in the NHIS weighting procedure. A final weighted data file covering the entire calendar year of data collection will be available during 1986.

The following Federal agencies provided partial funding for the 1985 Health Promotion and Disease Prevention Supplement:

- Office of the Assistant Secretary for Health
  - Office of Disease Prevention and Health Promotion
- Alcohol, Drug Abuse, and Mental Health Administration
  - National Institute of Alcohol Abuse and Alcoholism
- National Institutes of Health
  - National Heart, Lung, and Blood Institute
  - National Cancer Institute
  - National Institute of Dental Research
  - National Institute of Child Health and Human Development
- Health Resources and Services Administration
- Centers for Disease Control
  - Center for Prevention Services
  - Center for Infectious Diseases
  - Center for Environmental Health
  - Center for Health Promotion and Education
  - National Institute for Occupational Safety and Health

Symbols

...	Category not applicable
0	Quantity more than zero but 0.5 or less

Table 1. Provisional estimates of the percent of population with selected behaviors and knowledge from the 1985 National Health Interview Survey Supplement on Health Promotion and Disease Prevention, by age and sex: United States, January-March 1985

(Data are based on household interviews of the civilian noninstitutionalized population. The survey design, general qualifications, and information on the reliability of the estimates are given in technical notes.)

Section and item number	Health behaviors and knowledge	Age					Sex	
		All ages	18-29 years	30-44 years	45-64 years	65 years and over	Male	Female
		Percent of population						
	Total	100	100	100	100	100	100	100
	GENERAL HEALTH HABITS							
N.1.	How often do you eat breakfast?[1]							
	Almost every day	55	42	46	62	87	55	56
	Sometimes	19	27	22	16	6	20	19
	Rarely or never	25	31	32	22	8	26	25
N.2.	Including evening snacks how often do you eat between meals?[1]							
	Almost every day	39	42	42	37	32	40	38
	Sometimes	31	37	32	29	24	28	34
	Rarely or never	30	21	26	35	45	32	28
N.3.	When you visit a doctor or other health professional for routine care, is eating proper foods discussed?							
	Often	10	7	8	13	11	8	11
	Sometimes	16	18	15	16	15	14	18
	Rarely or never	66	67	69	62	66	66	66
	Don't visit for routine care	8	7	8	9	9	12	5
N.5.	In your opinion which of these are the two best ways to lose weight?							
	Don't eat at bedtime	28	29	25	29	30	30	27
	Eat fewer calories	75	70	77	79	73	70	79
	Take diet pills	1	2	1	1	1	1	1
	Increase physical activity	73	84	81	66	53	74	73
	Eat no fat	10	6	8	12	20	11	10
	Eat grapefruit with each meal	5	5	3	0	7	5	4
	Don't know	7	3	5	7	15	8	6
N.6.	Are you now trying to lose weight?[2] (Yes)	37	35	41	41	25	27	46
N.7.	Are you eating fewer calories to lose weight?[2] (Persons trying to lose weight (yes) in N.6) (Yes)	82	77	84	87	77	77	85
N.8.	Have you increased your physical activity to lose weight?[2] (Persons trying to lose weight (yes) in N.6) (Yes)	57	72	59	49	38	58	57
N.9.	Do you consider yourself overweight, underweight, or just about right? (If overweight) Would you say you are very overweight, somewhat overweight, or only a little overweight?[2,3]							
	Very overweight	8	5	9	12	7	4	12
	Somewhat overweight	17	13	19	22	14	13	21
	Only a little overweight	20	18	22	21	20	19	21
	About right	46	56	45	41	52	56	42
	Underweight	6	8	5	4	8	8	4
N.10	On the average, how many hours of sleep do you get in a 24-hour period?[1]							
	Less than 7 hours	22	21	24	22	19	22	22
	7-8 hours	66	65	69	68	59	67	65
	9 or more hours	12	14	7	10	21	11	13
N.11.	Is there a particular clinic, health center, doctor's office, or other place that you usually go to if you are sick or need advice about your health?[4] (Yes)	78	70	75	82	88	72	82
N.15.	About how long has it been since you had a Pap smear test?[5] (Females only)							
	Less than 1 year	44	59	47	36	23	...	44
	1 year	18	16	22	19	14	...	18
	2 years	10	7	11	12	12	...	10
	3-4 years	8	4	9	10	11	...	8
	5 or more years	12	3	9	19	25	...	12
	Never	7	12	2	5	15	...	7

See footnotes at end of table.

Table 1. Provisional estimates of the percent of population with selected behaviors and knowledge from the 1985 National Health Interview Survey Supplement on Health Promotion and Disease Prevention, by age and sex: United States, January-March 1985--Con.

(Data are based on household interviews of the civilian noninstitutionalized population. The survey design, general qualifications, and information on the reliability of the estimates are given in technical notes.)

Section and item number	Health behaviors and knowledge	Age					Sex	
		All ages	18-29 years	30-44 years	45-64 years	65 years and over	Male	Female
	GENERAL HEALTH HABITS--Con.	Percent of population						
N.16a.	About how long has it been since you had a breast examination by a doctor or other health professional?[5] (Females only)							
	Less than 1 year	49	59	50	45	39	...	49
	1 year	18	17	22	18	14	...	18
	2 years	10	7	11	10	11	...	10
	3-4 years	7	4	8	8	7	...	7
	5 or more years	8	3	7	12	15	...	8
	Never	8	10	2	6	15	...	8
N.16b.	Do you know how to examine your own breasts for lumps? (Females only) (Yes)	88	87	92	90	80	...	88
N.16c.	About how many times a year do you examine your own breasts for lumps? (Females only)							
	12 or more times	32	26	35	34	31	...	32
	7-11 times	3	2	3	3	2	...	3
	2-6 times	36	37	39	35	27	...	36
	Once a year	4	5	4	4	4	...	4
	Never	14	16	11	13	15	...	14
	Don't know how to examine own breast	12	13	8	10	20	...	12
	INJURY CONTROL AND CHILD SAFETY AND HEALTH							
O.1a.	Have you ever heard about Poison Control Centers? (Persons in families with children under 10 years of age) (Yes)	91	89	93	80	68	88	93
O.1b.	Do you have the telephone number for a Poison Control Center in your area? (Persons in families with children under 10 years of age) (Yes)	61	57	66	48	13	58	63
O.3.	Have you heard about child safety seats, sometimes called car safety carriers, which are designed to carry children while they are riding in a car? (Persons in families with children under 5 years of age) (Yes)	98	98	98	100	100	98	99
O.4.	Did a doctor or other health professional ever tell you about the importance of using car safety seats for your children? (Persons in families with children under 5 years of age) (Yes)	45	50	41	33	18	37	51
O.10.	When driving or riding in a car, do you wear a seat belt[3]--							
	All or most of the time	30	30	34	29	26	29	31
	Some of the time	18	19	18	18	14	16	19
	Once in awhile	16	16	15	16	15	16	15
	Never	36	34	32	36	42	37	34
	Don't ride in car	1	0	1	1	2	1	1
	Does this home have any working smoke detectors? (Based on Items O.11a.-c.) (Yes)	58	54	62	59	54	58	57
O.12a.	Do you know about what the hot water temperature is in this home? (Yes)	35	25	39	43	34	46	25
O.13.	In the past 12 months, have you (or has anyone in your household) used a thermometer to test the temperature of the hot water here? (Yes)	4	4	5	4	3	4	4
O.14.	Above what temperature will hot water cause scald injuries?							
	127 degrees or less	14	20	16	11	6	16	12
	128-139 degrees (can produce burns in less than a minute)	2	3	3	2	1	3	2
	140 degrees or above (can produce burns in 5 seconds or less)	21	16	20	27	20	31	12
	Don't know	63	61	61	60	74	49	74

See footnotes at end of table.

Table 1. Provisional estimates of the percent of population with selected behaviors and knowledge from the 1985 National Health Interview Survey Supplement on Health Promotion and Disease Prevention, by age and sex: United States, January-March 1985--Con.

(Data are based on household interviews of the civilian noninstitutionalized population. The survey design, general qualifications, and information on the reliability of the estimates are given in technical notes.)

Section and item number	Health behaviors and knowledge	Age					Sex	
		All ages	18-29 years	30-44 years	45-64 years	65 years and over	Male	Female
	HIGH BLOOD PRESSURE	Percent of population						
P.1.	I am going to read a list of things which may or may not affect a person's chances of getting heart disease. After I read each one, tell me if you think it definitely increases, probably increases, probably does not, or definitely does not increase a person's chances of getting heart disease.							
	Cigarette smoking							
	Increases	91	94	93	91	83	91	92
	Does not increase	3	3	3	3	5	4	3
	Don't know/No opinion	5	3	4	6	12	5	5
	Worry or anxiety							
	Increases	85	84	87	86	80	84	86
	Does not increase	8	11	8	7	6	9	8
	Don't know/No opinion	7	5	5	7	14	7	7
	High blood pressure							
	Increases	92	93	94	92	83	91	92
	Does not increase	3	3	2	3	4	3	2
	Don't know/No opinion	6	4	4	5	13	6	6
	Diabetes							
	Increases	60	65	64	58	48	60	60
	Does not increase	11	11	11	10	10	11	11
	Don't know/No opinion	29	24	25	32	42	29	29
	Being very overweight							
	Increases	94	95	96	95	87	94	94
	Does not increase	2	2	2	2	3	2	2
	Don't know/No opinion	4	2	2	3	10	4	4
	Overwork							
	Increases	72	78	78	67	59	69	75
	Does not increase	19	16	15	23	22	22	16
	Don't know/No opinion	9	6	7	10	19	9	9
	Drinking coffee with caffeine							
	Increases	50	53	52	49	42	47	52
	Does not increase	29	31	29	29	27	32	27
	Don't know/No opinion	21	16	19	22	31	21	21
	Eating a diet high in animal fat							
	Increases	80	77	82	83	75	77	82
	Does not increase	8	9	8	7	7	10	6
	Don't know/No opinion	13	13	11	10	18	14	12
	Family history of heart disease							
	Increases	82	87	85	82	69	79	85
	Does not increase	8	6	7	9	12	10	6
	Don't know/No opinion	10	7	7	9	19	10	9
	High cholesterol							
	Increases	86	89	89	87	76	85	87
	Does not increase	4	5	4	4	5	5	4
	Don't know/No opinion	9	6	7	9	19	9	9
P.2.	The following conditions are related to having a stroke. In your opinion, which of these conditions most increases a person's chances of having a stroke?							
	Diabetes	5	6	4	4	3	5	4
	High blood pressure	78	74	80	81	75	76	79
	High cholesterol	12	15	12	10	9	13	11
	Don't know	6	4	5	6	12	6	6
P.3.	Which one of the following substances in food is most often associated with high blood pressure?							
	Sodium (or salt)	59	59	64	60	48	57	61
	Cholesterol	24	27	22	25	23	24	24
	Sugar	9	10	7	7	14	11	7
	Don't know	8	5	6	8	16	8	7

See footnotes at end of table

Table 1. Provisional estimates of the percent of population with [illegible] 1985 National Health Interview Survey Supplement on Health Promotion and Disease Prevention, by age and sex: United States, January-March 1985--Con.

(Data are based on household interviews of the civilian noninstitutionalized population. The survey design, general qualifications, and information on the reliability of the estimates are given in technical notes.)

Section and item number	Health behaviors and knowledge	Age					Sex	
		All ages	18-29 years	30-44 years	45-64 years	65 years and over	Male	Female
	HIGH BLOOD PRESSURE- Con.	Percent of population						
P.12a.	About how long has it been since you last had your blood pressure taken by a doctor or other health professional?[2,3]							
	Less than 6 months	54	50	48	57	70	49	60
	6-11 months	19	21	21	16	14	18	19
	12 months to 23 months	14	16	15	14	7	16	12
	24 months and over	13	13	15	13	9	17	10
P.12b.	Blood pressure is usually given as one number over another. Were you told what your blood pressure was, in numbers? (Persons with blood pressure checked within 24 months in 12a) (Yes)	70	67	71	72	68	72	68
P.14.	Have you ever been told by a doctor or other health professional that you had high cholesterol? (Yes)	5	1	3	9	11	5	5
	STRESS							
Q.1.	During the past 2 weeks, would you say that you experienced a lot of stress, a moderate amount of stress, relatively little stress, or almost no stress at all?							
	A lot of stress	20	23	24	18	12	18	22
	A moderate amount of stress	32	36	37	30	16	33	30
	Relatively little stress	22	23	20	22	22	21	22
	Almost none	25	17	18	28	46	26	24
	Don't know what stress is	2	1	1	2	5	2	2
Q.2.	In the past year, how much effect has stress had on your health?							
	A lot	13	12	15	14	9	10	16
	Some	31	33	35	29	21	28	33
	Hardly any or none	54	53	49	55	65	61	49
	Don't know what stress is	2	1	1	2	5	2	2
Q.3a.	In the past year, did you think about seeking help for any personal or emotional problems from family or friends? (Yes)	17	25	21	11	4	12	20
Q.3b.	In the past year, did you think about seeking help for any personal or emotional problems from a helping professional or a self-help group? (Yes)	12	14	17	9	4	10	14
Q.4.	Did you actually seek any help? (Yes) From whom did you seek help?							
	Family or friends	8	14	9	4	2	5	10
	Professional or self help group	7	8	11	6	3	6	9
	EXERCISE							
R.2a.	In the past 2 weeks, have you done any of the following exercises, sports, or physically active hobbies[8]--							
	Walking for exercise	40	43	39	39	41	38	43
	Jogging or running	11	24	12	4	1	15	8
	Calisthenics or general exercise	26	39	28	18	12	26	26
	Biking	9	11	9	8	5	9	9
	Swimming or water exercises	5	7	5	3	1	5	4
R.3.	Do you exercise or play sports regularly? (Yes)	41	55	44	31	27	44	38
R.4.	For how long have you exercised or played sports regularly?							
	Less than 1 year	5	8	6	4	2	3	7
	1-2 years	6	7	7	4	3	4	7
	3-4 years	3	4	4	3	3	3	4
	5 or more years	25	34	25	18	17	31	19
	Do not exercise regularly	59	45	56	69	73	56	62

See footnotes at end of table.

Table 1. Provisional estimates of the percent of population with selected behaviors and knowledge from the 1985 National Health Interview Survey Supplement on Health Promotion and Disease Prevention, by age and sex: United States, January-March 1985--Con.

[Data are based on household interviews of the civilian noninstitutionalized population. The survey design, general qualifications, and information on the reliability of the estimates are given in technical notes.]

Section and item number	Health behaviors and knowledge	All ages	Age: 18-29 years	Age: 30-44 years	Age: 45-64 years	Age: 65 years and over	Sex: Male	Sex: Female
	EXERCISE- Con.	Percent of population						
R.5a.	Would you say that you are physically more active, less active, or about as active as other persons your age?[1,3] Is that (a lot more or a little more/a lot less or a little less) active?							
	A lot more	18	16	17	18	23	22	15
	A little more	15	13	15	15	17	16	13
	About as active	49	50	48	49	47	48	49
	A lot less	6	5	6	8	7	4	8
	A little less	12	16	14	10	7	10	14
R.7a.	How many days a week do you think a person should exercise to strengthen the heart and lungs?							
	Less than 3 days	6	8	7	5	3	6	6
	3-4 days	40	54	48	32	16	41	40
	5 days or more	38	32	34	44	45	38	38
	Don't know	16	6	10	20	36	15	16
R.7b.	For how many minutes do you think a person should exercise on each occasion so that the heart and lungs are strengthened?							
	Less than 15 minutes	6	4	5	8	10	5	7
	15 to 25 minutes	24	23	27	25	19	23	25
	More than 25 minutes	50	66	56	42	26	54	47
	Don't know	19	7	12	26	45	18	20
R.7c.	During those (number in 7b) minutes, how fast do you think a person's heart rate and breathing should be to strengthen the heart and lungs? Do you think that the heart and breathing rate should be--							
	No faster than usual	4	3	2	4	8	3	4
	A little faster than usual	44	45	43	44	45	43	45
	A lot faster but talking is possible	36	46	44	30	11	38	33
	So fast that talking is not possible	1	1	1	1	0	1	1
	Don't know	16	5	10	21	36	15	17
	SMOKING							
	Cigarette smoking status (Based on items S.1-3)							
	Never	45	56	41	37	48	36	54
	Former	25	14	23	32	36	32	18
	Current (Includes unknown amount smoked)	30	30	36	31	16	33	28
	Less than 15	9	12	10	7	6	9	10
	15-24	12	13	14	13	7	13	12
	25 and over	8	5	12	10	3	10	6
S.3.	On the average, about how many cigarettes a day do you now smoke?[7] (Current smokers)							
	Less than 15	31	41	28	24	37	28	35
	15-24	41	42	39	42	46	41	42
	25 and over	27	17	33	34	17	31	23
S.4.	Tell me if you think cigarette smoking definitely increases, probably increases, probably does not, or definitely does not increase a person's chances of getting the following problems?							
	Emphysema							
	Increases	92	91	94	92	88	92	91
	Does not increase	2	2	2	2	1	2	2
	Don't know/No opinion	7	7	4	6	11	6	7
	Bladder cancer							
	Increases	35	41	33	34	31	37	34
	Does not increase	25	30	30	21	14	24	25
	Don't know/No opinion	40	28	37	45	55	39	40

Table 1. Provisional estimates of the percent of population with selected behaviors and knowledge from the 1985 National Health Interview Survey Supplement on Health Promotion and Disease Prevention, by age and sex: United States, January-March 1985--Con.

[Data are based on household interviews of the civilian noninstitutionalized population. The survey design, general qualifications, and information on the reliability of the estimates are given in technical notes.]

Section and item number	Health behaviors and knowledge	Age					Sex	
		All ages	18-29 years	30-44 years	45-64 years	65 years and over	Male	Female
	SMOKING -Con.	Percent of population						
S.4.	Tell me if you think cigarette smoking definitely increases, probably increases, probably does not, or definitely does not increase a person's chances of getting the following problems?- Con.							
	Cancer of the larynx or voice box							
	Increases	88	92	92	86	77	87	89
	Does not increase	3	3	3	3	4	4	3
	Don't know/No opinion	9	5	6	10	19	9	8
	Cataracts							
	Increases	16	21	14	14	11	17	14
	Does not increase	41	46	47	37	27	41	41
	Don't know/No opinion	43	33	38	49	61	42	44
	Cancer of the esophagus							
	Increases	80	85	83	78	70	79	81
	Does not increase	6	5	7	6	6	7	5
	Don't know/No opinion	14	9	10	16	24	14	14
	Chronic bronchitis							
	Increases	87	90	89	86	77	86	87
	Does not increase	4	4	5	4	5	5	4
	Don't know/No opinion	9	6	6	9	18	9	9
	Gallstones							
	Increases	11	14	9	9	9	11	11
	Does not increase	45	51	51	41	31	46	44
	Don't know/No opinion	44	35	40	49	60	43	45
	Lung cancer							
	Increases	95	98	97	94	88	95	95
	Does not increase	1	1	1	2	2	1	1
	Don't know/No opinion	4	1	2	5	9	4	4
S.4.	Does cigarette smoking during pregnancy definitely increase, probably increase, probably not or definitely not increase the chances of--(Persons under 45 years of age)							
	Miscarriage							
	Increases	74	79	70	...	...	74	75
	Does not increase	12	10	13	...	...	10	14
	Don't know/No opinion	14	10	17	...	...	16	12
	Stillbirth							
	Increases	65	71	60	...	...	64	67
	Does not increase	15	13	16	...	...	13	16
	Don't know/No opinion	20	16	23	...	...	23	17
	Premature birth							
	Increases	70	75	66	...	...	65	75
	Does not increase	13	11	14	...	...	13	12
	Don't know/No opinion	17	14	20	...	...	22	13
	Low birth weight of the newborn							
	Increases	80	83	76	...	...	74	05
	Does not increase	7	6	9	...	...	8	7
	Don't know/No opinion	13	11	15	...	...	18	9
S.5a.	If a woman takes birth control pills, is she more likely to have a stroke if she smokes than if she does not smoke? (Persons under 45 years of age)							
	More likely	65	67	63	...	...	56	74
	Not likely	6	6	6	...	...	7	6
	Don't know	29	27	31	...	...	38	21

See footnotes at end of table

Table 1. Provisional estimates of the percent of population with selected behaviors and knowledge from the 1985 National Health Interview Survey Supplement on Health Promotion and Disease Prevention, by age and sex: United States, January-March 1985--Con.

[Data are based on household interviews of the civilian noninstitutionalized population. The survey design, general qualifications, and information on the reliability of the estimates are given in technical notes.]

Section and item number	Health behaviors and knowledge	Age					Sex	
		All ages	18-29 years	30-44 years	45-64 years	65 years and over	Male	Femal
	ALCOHOL USE	Percent of population						
T.1c.	Have you had at least one drink of beer, wine or liquor during the past year?[1] (Yes)	66	76	74	62	41	77	57
T.2.	In the past 2 weeks, on how many days did you drink any alcoholic beverages, such as beer, wine, or liquor?[1,3]							
	Did not drink in past year	34	24	26	38	59	23	43
	None	14	14	15	14	11	13	14
	1-4 days	32	43	37	26	15	35	30
	5-9 days	9	12	10	8	3	13	5
	10-14 days	11	7	11	14	11	15	7
T.3.	In the past 2 weeks, on the days that you drank alcoholic beverages, how many drinks did you have per day, on the average?[1,3]							
	Did not drink in past year	34	24	26	38	59	23	43
	None	14	14	15	14	11	13	14
	1 drink	16	11	18	18	16	15	16
	2 drinks	16	17	18	15	8	18	13
	3-4 drinks	13	19	14	10	3	17	9
	5 or more drinks	8	14	8	5	2	13	4
	Drinking Index (2-week daily drinking, based on items T.1-3)[7]							
	Did not drink in past year	34	24	26	38	59	23	43
	None	14	14	15	14	11	13	14
	Light (.01 to .21 ounce absolute alcohol)	24	27	28	22	14	23	24
	Moderate (.22 to .99 ounce absolute alcohol)	20	26	23	17	10	27	15
	Heavier (1.00 ounces or more absolute alcohol)	8	9	7	9	6	14	3
T.6.	During the past 12 months, on how many days did you have 9 or more drinks of any alcoholic beverage?							
	1 or more days	13	26	13	7	2	23	5
	5 or more days	7	15	7	4	1	14	2
T.7.	During the past 12 months, on how many days did you have 5 or more drinks of any alcoholic beverage?[1]							
	1 or more days	26	44	30	16	6	39	15
	10 or more days	14	25	14	8	3	23	5
T.8.	During the past year, how many times did you drive when you had perhaps too much to drink?							
	1 time	4	7	5	1	0	5	3
	2 or more times	8	16	9	3	1	13	3
T.9.	Tell me if you think heavy alcohol drinking definitely increases, probably increases, probably does not, or definitely does not increase a person's chances of getting the following problems?							
	Throat cancer							
	Increases	39	39	36	39	46	38	40
	Does not increase	35	42	40	31	17	38	31
	Don't know/No opinion	26	19	24	30	38	24	29
	Cirrhosis of the liver							
	Increases	95	96	97	95	89	95	95
	Does not increase	1	1	1	1	1	1	1
	Don't know/No opinion	4	3	2	4	10	4	4
	Bladder cancer							
	Increases	66	73	68	64	55	67	65
	Does not increase	11	12	13	11	7	12	11
	Don't know/No opinion	22	15	19	25	37	21	24

See footnotes at end of table.

Table 1. Provisional estimates of the percent of population with selected behaviors and knowledge from the 1985 National Health Interview Survey Supplement on Health Promotion and Disease Prevention, by age and sex: United States, January-March 1985--Con.

[Data are based on household interviews of the civilian noninstitutionalized population. The survey design, general qualifications, and information on the reliability of the estimates are given in technical notes.]

Section and item number	Health behaviors and knowledge	Age					Sex	
		All ages	18-29 years	30-44 years	45-64 years	65 years and over	Male	Female
	ALCOHOL USE--Con.	Percent of population						
T.9.	Tell me if you think heavy alcohol drinking definitely increases, probably increases, probably does not, or definitely does not increase a person's chances of getting the following problems?- Con.							
	Cancer of the mouth							
	Increases	31	30	27	32	38	29	33
	Does not increase	37	45	43	31	20	42	32
	Don't know/No opinion	32	25	30	36	43	30	35
	Arthritis							
	Increases	13	15	12	13	13	14	13
	Does not increase	46	55	50	41	29	47	44
	Don't know/No opinion	41	30	38	45	58	38	43
	Blood clots							
	Increases	34	45	32	28	27	34	34
	Does not increase	31	31	37	32	20	34	28
	Don't know/No opinion	35	24	31	40	53	32	37
T.9.	Does heavy drinking during pregnancy definitely increase, probably increase, probably not or definitely not increase the chances of--(Persons under 45 years of age)							
	Miscarriage							
	Increases	86	90	82	...	...	86	86
	Does not increase	4	3	5	...	...	3	6
	Don't know/No opinion	10	7	12	...	...	11	8
	Mental retardation of the newborn							
	Increases	84	88	80	...	...	82	86
	Does not increase	5	4	6	...	...	6	5
	Don't know/No opinion	11	8	13	...	...	12	9
	Low birth weight of the newborn							
	Increases	85	87	82	...	...	81	88
	Does not increase	4	4	4	...	...	5	3
	Don't know/No opinion	11	9	13	...	...	14	8
	Birth defects							
	Increases	85	89	81	...	...	82	88
	Does not increase	5	4	6	...	...	6	4
	Don't know/No opinion	10	7	13	...	...	12	8
T.10.	Have you ever heard of Fetal Alcohol Syndrome? (Persons under 45 years of age) (Yes)	58	55	60	...	...	52	63
	DENTAL CARE							
U.1.	This next question is about preventing tooth decay. After I read each of the following, tell me if you think it is definitely important, probably important, probably not, or definitely not important in preventing tooth decay							
	Seeing a dentist regularly							
	Important	96	97	97	95	93	95	97
	Not important	2	2	2	2	2	3	1
	Don't know/No opinion	2	1	1	2	4	2	2
	Drinking water with fluoride from early childhood							
	Important	80	86	86	77	62	79	81
	Not important	8	9	7	8	7	9	[illegible]
	Don't know/No opinion	12	5	[illegible]	15	30	12	12
	Regular brushing and flossing of the teeth							
	Important	98	99	99	97	95	98	98
	Not important	1	0	0	1	1	1	1
	Don't know/No opinion	1	0	1	2	4	2	1

See footnotes at end of table.

Table 1. Provisional estimates of the percent of population with selected behaviors and knowledge from the 1985 National Health Interview Survey Supplement on Health Promotion and Disease Prevention, by age and sex: United States, January-March 1985--Con.

[Data are based on household interviews of the civilian noninstitutionalized population. The survey design, general qualifications and information on the reliability of the estimates are given in technical notes.]

Section and item number	Health behaviors and knowledge	Age					Sex	
		All ages	18-29 years	30-44 years	45-64 years	65 years and over	Male	Female
	DENTAL CARE--Con.	Percent of population						
U.1	This next question is about preventing tooth decay. After I read each of the following, tell me if you think it is definitely important, probably important, probably not, or definitely not important in preventing tooth decay.- Con.							
	Using fluoride toothpaste or fluoride mouth rinse							
	Important	90	97	94	86	76	90	90
	Not important	4	2	3	5	5	4	3
	Don't know/No opinion	6	1	3	9	19	7	6
	Avoiding between meal sweets							
	Important	90	90	92	90	83	89	90
	Not important	6	8	6	5	6	7	5
	Don't know/No opinion	4	1	2	5	11	4	4
U 2.	Now I'm going to ask about preventing gum disease. In your opinion, how important or not important is each of the following in preventing gum disease?							
	Seeing a dentist regularly							
	Important	96	97	97	95	92	95	96
	Not important	2	2	2	3	2	3	1
	Don't know/No opinion	2	1	1	3	6	2	2
	Drinking water with fluoride from early childhood							
	Important	66	74	67	62	54	64	67
	Not important	17	18	19	17	10	19	15
	Don't know/No opinion	17	8	13	21	36	18	17
	Regular brushing and flossing of the teeth							
	Important	96	98	98	95	92	96	97
	Not important	1	1	1	1	2	1	1
	Don't know/No opinion	3	1	1	3	7	3	2
	Using fluoride toothpaste or fluoride mouth rinse							
	Important	78	86	78	73	71	76	80
	Not important	12	10	15	12	7	13	10
	Don't know/No opinion	11	4	8	14	22	11	11
	Avoiding between-meal sweets							
	Important	81	84	81	80	78	80	82
	Not important	12	13	13	11	8	13	10
	Don't know/No opinion	7	3	5	9	14	7	7
U 3	In your opinion, which of the following is the main cause of tooth loss in children?							
	Tooth decay	58	54	57	61	60	55	60
	Gum disease	8	8	7	9	9	10	7
	Injury to the teeth	30	36	35	26	18	31	30
	Don't know	4	1	2	4	13	4	4
U 4	In your opinion, which of the following is the main cause of tooth loss in adults?							
	Tooth decay	40	40	37	40	44	41	38
	Gum disease	55	55	60	55	43	53	57
	Injury to the teeth	2	3	2	2	3	3	2
	Don't know	3	1	1	3	10	3	3
U 5a.	Have you ever heard of dental sealants? (Yes)	23	20	30	23	14	22	23

See footnotes at end of table.

Table 1. Provisional estimates of the percent of population with selected behaviors and knowledge from the 1985 National Health Interview Survey Supplement on Health Promotion and Disease Prevention, by age and sex: United States, January-March 1985--Con.

[Data are based on household interviews of the civilian noninstitutionalized population. The survey design, general qualifications, and information on the reliability of the estimates are given in technical notes.]

Section and item number	Health behaviors and knowledge	All ages	Age				Sex	
			18-29 years	30-44 years	45-64 years	65 years and over	Male	Female
	OCCUPATIONAL SAFETY AND HEALTH	Percent of population						
V.1a.	In your present job, are you exposed to any substances that could endanger your health, such as chemicals, dusts, fumes or gases?[3] (Currently employed persons) (Yes)	36	36	37	34	18	45	24
V.2a.	In your present job, are you exposed to any work conditions that could endanger your health, such as loud noise, extreme heat or cold, physical or mental stress, or radiation?[3] (Currently employed persons) (Yes)	37	36	41	33	15	43	29
V.3a.	In your present job are you exposed to any risks of accidents or injuries?[3] (Currently employed persons) (Yes)	41	44	41	38	34	52	27

[1] National Center for Health Statistics, C. A. Schoenborn and K. M. Danchik: Health Practices Among Adults: United States, 1977. Advance Data From Vital and Health Statistics. No. 64. DHEW Pub. No. (PHS) 78-1250. Public Health Service. Hyattsville, Md., Nov. 4, 1980.

[2] National Center for Health Statistics, A. J. Moss and G. Scott: Characteristics of persons with hypertension, United States, 1974. Vital and Health Statistics. Series 10, No. 121. DHEW Pub. No. (PHS) 79-1549. Public Health Service. Washington. U.S. Government Printing Office, Dec. 1978.

[3] National Center for Health Statistics, C. A. Schoenborn, K. M. Danchik, and J. Elinson: Basic data from Wave I of the National Survey of Personal Health Practices and Consequence, United States, 1979. Vital and Health Statistics. Series 15, No. 2. DHHS Pub. No. (PHS) 81-1163. Public Health Service. Washington. U.S. Government Printing Office, Aug. 1981.

[4] National Center for Health Statistics, B. Bloom and S. S. Jack: Persons with and without a regular source of medical care, United States. Vital and Health Statistics. Series 10, No. 151. DHHS Pub. No. (PHS) 85-1579.

[5] National Center for Health Statistics, A. J. Moss and M. H. Wilder: Use of selected medical procedures associated with preventive care, United States, 1973. Vital and Health Statistics. Series 10, No. 110. DHEW Pub. No. (HRA) 77-1538. Health Resources Administration. Washington. U.S. Government Printing Office, Mar. 1977.

[6] National Center for Health Statistics, J. W. Choi: Exercise and Participation in Sports Among Persons 20 Years of Age and Over: United States, 1975. Advance Data From Vital and Health Statistics. No. 19. DHEW Pub. No. (PHS) 78-1250. Public Health Service. Hyattsville, Md., March 15, 1978.

[7] National Center for Health Statistics: Health, United States, 1984. DHHS Pub. No. (PHS) 85-1232. Public Health Service. Washington. U.S. Government Printing Office, Dec. 1984.

Technical notes

The National Health Interview Survey (NHIS) is a continuous, cross-sectional, nationwide survey conducted by household interview. Each week a probability sample of households is interviewed by personnel of the U.S. Bureau of the Census to obtain information on the health and other characteristics of each member of the household in the civilian noninstitutionalized population.

During the first quarter of 1985, the sample consisted of approximately 9,250 households. The total noninterview rate was about 4 percent—about 3 percent of which was due to respondent refusal and the remainder primarily due to an inability to locate an eligible respondent at home after repeated calls. Information was obtained for all household members for the core section of the questionnaire, although, for the Health Promotion and Disease Prevention Supplement, one adult per family was randomly selected as the respondent. This procedure resulted in an additional nonresponse rate of about 10 percent. About 8,350 supplements were completed. A description of the survey design, methods used in estimation, and general qualifications of the NHIS data is provided in *The National Health Interview Survey Design, 1973-84, and Procedures, 1975-83* (see pp. 8-9)[3]

[3]National Center for Health Statistics, M. G. Kovar and G. S. Poe: The National Health Interview Survey Design, 1973-84, and Procedures, 1975-83. *Vital and Health Statistics*. Series 1, No. 18. DHHS Pub. No. (PHS) 85-1320. Public Health Service. Washington. U.S. Government Printing Office, Aug. 1985.

The estimates shown in this report are based on a sample of the civilian noninstitutionalized population rather than on the entire population and are therefore subject to sampling error. Some tables in this report contain cells in which the estimate is small for a given characteristic. When an estimate or the numerator or denominator of a rate is small, the sampling error may be relatively high. The estimated population for each of the demographic categories presented in this report is given in table I. Approximate standard errors of estimates are shown in table II.

To expedite the early release of data from the Health Promotion and Disease Prevention Supplement, it was processed separately from the NHIS core questionnaire. Thus the supplement has not been linked as yet with the core data. In addition, since there were also major changes in the sample design in 1985, both the estimates of behaviors and knowledge and the standard errors of the estimates shown in table II are provisional and will be modified when the final estimates based on the linked core are released.

Table I. Provisional estimates of the civilian noninstitutionalized population by age and sex: United States, January–March 1985

Selected populations	Age					Sex	
	All ages	18–29 years	30–44 years	45–64 years	65 years and over	Male	Female
	Population in thousands						
Total adult population	170 302	48 524	50 463	44.476	26.839	80 461	89.840
Females	89 840	24 856	25 882	23.284	15 818		89.840
Population in families with children under 10 years of age	42 318	16 396	22.412	3.134	375	18.350	23.968
Population in families with children under 5 years of age	26 064	13 256	11.425	1.251	132	11.634	14.430
Currently employed population	105 292	33 333	40 089	28.887	2.983	57 938	47.355

Table II. Standard errors, expressed in percentage points, of estimated percents for selected age and sex groups from the 1985 National Health Interview Survey Supplement on Health Promotion and Disease Prevention: United States, January–March 1985

Estimated percent	Age: All ages	Age: 18–29 years	Age: 30–44 years	Age: 45–64 years	Age: 65 years and over	Sex: Male	Sex: Female
	Standard error in percentage points						
5 or 95	0.26	0.50	0.48	0.53	0.60	0.40	0.34
10 or 90	0.36	0.69	0.66	0.73	0.83	0.55	0.47
15 or 85	0.43	0.82	0.78	0.87	0.99	0.65	0.56
20 or 80	0.48	0.92	0.87	0.97	1.11	0.73	0.63
25 or 75	0.52	1.00	0.96	1.05	1.20	0.79	0.68
30 or 70	0.56	1.06	1.00	1.11	1.27	0.84	0.72
35 or 65	0.57	1.10	1.04	1.16	1.32	0.87	0.75
40 or 60	0.59	1.13	1.07	1.19	1.36	0.90	0.77
45 or 55	0.60	1.15	1.09	1.21	1.38	0.91	0.79
50 or 50	0.60	1.15	1.09	1.21	1.38	0.92	0.79

BEST AVAILABLE COPY

The Tobacco Institute Enclosure 2.

THE RESPONSIBLE LIVING PROGRAM

- In 1984 – The Institute launched its current "Responsible Living" program by offering a free parental guidebook, "Helping Youth Decide," prepared by the National Association of State Boards of Education. Another booklet, "Helping Youth Say No" followed in 1986. Both provide guidance on family communication to enable parents to help youngsters develop decision-making skills needed to deal wisely with everyday choices and with lifestyle decisions such as smoking.

These two Tobacco Institute-funded booklets, "Helping Youth Decide" and "Helping Youth Say No" comprise the core of the program. Since their introduction, they have helped thousands of parents and teachers assist children in making decisions about important adult activities.

Their success has been remarkable. More than 700,000 booklets have been distributed nationwide at a cost of more than half a million dollars for printing alone. Initially advertised in national general interest and news magazines, demand continues to be high among parents and community organizations, where these materials are used to teach communications skills to parents and teens to discuss subjects as diverse as teen-age pregnancy, the impact of divorce on children, improving school performance and how to handle peer pressure.

The booklets have generated large numbers of unsolicited letters of appreciation from parents and support groups who have used these materials. Several Congressmen have sent them to all public high school students in their districts. One Catholic bishop has sent copies to all parochial high school students in his diocese.

Here are some typical comments:

> "Our program works to keep parents and children together, and your booklets are right on target in terms of dealing with the care issues...Thank you again for developing such a viable tool and also for being willing to distribute it free of charge. You are providing a very valuable service."
>
> Milwaukee County Social Services,
> Milwaukee, Wisconsin

> "...have found it invaluable in my work with parents and youth. The copies I am requesting will be used at several parenting workshops."
>
> Public Health Nurse, Mental Health Center,
> High Point, North Carolina

The Tobacco Institute
Page Two

"As the parent of one teen and two who will soon be teens (and as president of PTA Council), I found the information in the booklets just great. It is a great common sense approach to dealing with the issue which is most on the minds of parents today."

Greensburg, Pennsylvania

The Institute continues to promote the booklets to parents and teachers around the country through media appearances by the program's national spokesperson, Jolly Ann Davidson, a former president of NASBE. Upon hearing interviews conducted by Ms. Davidson, parents or young people can send for their free booklet. Interest generated by Ms. Davidson's appearances underlines the continued need to help parents and their children improve communications.

- o In 1986 -- The Institute expanded the "Responsible Living" program by providing unrestricted grants to the National Association of State Boards of Education (NASBE) for funding Community Alliance Programs (CAPs) at the rate of ten a year. Towns and cities throughout the U.S. were invited to apply for the grants, which provide the impetus for a broad community-based effort to improve parent-youth interaction, using "Helping Youth Decide" and "Helping Youth Say No" booklets.

- o The total expenditure for this program from its inception to date has been more than $5.6 million.

The Community Alliance Program (CAP), also revolves around these booklets, each community tailoring its programs and the use of the booklets to meet specific needs. For example,

In Queens, New York, a CAP began as an informal group of parents concerned about drinking at teenage parties. It subsequently became an incorporated non-profit community service organization. The "Helping Youth Decide" booklet was used in these parent education workshops, targeted toward minority parents and the parents of at-risk students.

In Colorado Springs, Colorado, the CAP was formed within a middle school-based program focusing on building communication between young adolescents, parents and step-parents. Program coordinators use the "Helping Youth Decide" material to expand a program to develop peer leaders in drug and alcohol use/abuse situations and in general problem solving.

Many CAP programs are launched with seed money from The Tobacco Institute are freestanding today and continue to serve communities throughout the country.

COMMUNICATIONS

STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

The American Public Health Association (APHA), representing a combined national and affiliate membership of over 55,000 public health professionals and community health leaders, strongly supports S. 776, a bill to disallow tax deductions for tobacco product advertising expenses, and S. 801, a bill to increase the excise tax on cigarettes by 22 cents per pack.

These two bills are directly in line with APHA policy. Since first recognizing the harmful health effects of tobacco in 1959, APHA has been a leader in the fight against tobacco-related morbidity and mortality. In its efforts, APHA has supported all efforts to limit tobacco advertising. Our organization has also favored increased excise taxes on tobacco products. In 1986, APHA adopted a policy supporting an increase in the Federal taxes on tobacco by a factor of five or more.

Both of these bills are supported by a wealth of evidence pointing to the enormous human and economic costs of tobacco consumption. In 1989, the Surgeon General estimated that smoking is directly responsible for 390,000 deaths each year in the United States (US DHHS 1989). The prevalence of tobacco consumption among women and children is particularly frightening. While smoking rates, in general, have been decreasing, the rate of decrease has been much slower among women than among men. In addition, an alarming number of America's teens are smoking. The Surgeon General estimates that every day over 3,000 teens take up smoking (US DHHS 1989). More than 80 percent of all smokers initiate smoking before the age of 21 (US DHHS 1989).

The financial implications of these figures are tremendous. A recent Department of Health and Human Services study, entitled *Smoking and Health, A national Status Report,* estimated that smoking costs the nation more than $52 billion annually. This equates to $221 per year for each American, smoker and non-smoker alike (US DHHS 1990). The increased burden is reflected in higher health-care and insurance costs. Thus Medicare and Medicaid expenses are increased. Not included in these figures are losses in work productivity, which constitute yet another cost of tobacco consumption.

Tragically, these human and economic costs are being maintained and even increased by the advertising tactics of tobacco companies. The Surgeon General's 1989 report presents several studies which indicate that decreasing the amount of tobacco advertising would decrease smoking prevalence rates (US DHHS 1989). These studies associate recognition and approval of cigarette advertisements with subsequent propensity to smoke.

It is especially disturbing that tobacco companies increase consumption rates through deceptive advertising. A 1981 report by the Federal Trade Commission concluded that cigarette advertising may be deceptive because its themes and imagery may have a capacity or even a tendency to deceive (FTC 1981). Of most concern are advertisements that associate smoking with attractiveness, athletic success, popularity, affluence, and good health. Such ads run directly counter to the fact that tobacco smoke is a potent killer.

Not only are tobacco advertisements deceptive, but often they are also directed at women, children, and minorities. An example is R.J. Reynolds' marketing of "Uptown." Dr. Louis Sullivan, Secretary of the U.S. Department of Health and Human Services, effectively argued that the advertising of this product was targeted toward black Americans. Sullivan added that "Uptown's message is more disease, more suffering and more death for a group already bearing more than its share of smoking-related illness and mortality" (Schiffman 1990). The Uptown example is analogous to that of "Dakota," a cigarette which is being targeted at young, blue-

collar women. Still other advertisement campaigns, such as Camel's cartoon "Smooth Character," are directed at adolescents and children.

Clearly something must be done to put an end to this seduction of our citizens into tobacco addiction. The costs, in terms of lives and dollars, are simply too great. It is an outrage that current Federal policy forces our citizens to bear these costs while it simultaneously subsidizes tobacco adv-rtisements. S. 801, which would terminate government subsidization of tobacco product advertising, represents an excellent means to ending this outrageous policy.

Another effective means for decreasing tobacco consumption is increasing taxes on tobacco products. Many studies have demonstrated that increasing excise taxes on cigarettes would result in a profound decrease in smoking prevalence. For example, Dr. Kenneth E. Warner, of the University of Michigan, concluded that a "16-cent increase in the excise tax would encourage almost 3.5 million Americans to forego smoking habits in which they would engage if the tax were to remain at 16 cents per pack (the current value)" (Warner 1986). Other studies indicate that this tax is particularly effective in deterring teenagers from smoking. A 1989 GAO report estimated that a 21-cent-per-pack increase would reduce the number of teenage smokers by over 500,000. This translates into 125,000 fewer preventable deaths (U.S. GAO 1989). These two studies are supported by the recent experience in California, where in 1989 a 25-cent excise tax increase resulted in a 13.1 percent decrease in cigarette sales over a 9-month period (McAlister et al. 1990).

Increasing the excise tax would not only provide an effective deterrent to smoking but it would also be financially beneficial for the Federal Government. Increasing the excise tax by 25 cents per pack would generate an estimated $4.4 billion in new tax revenues (Coalition on Smoking or Health 1990).

Yet another piece of support for increasing the excise tax on cigarettes is that this measure is publicly supported. A 1989 Gallup Poll survey estimated that 76 percent of Americans favor increased taxes on tobacco products (Gallup 1989). In fact, the tax increase is supported by smokers and non-smokers alike: a 1983 Texas A&M University study found that 58 percent of smokers support new tobacco product taxes that would finance educational efforts (Texas Poll 1983).

In summary, tobacco consumption exacts a tremendous toll on our society, in terms of both lives and dollars. However, we have at hand the tools to put an end to this catastrophe. S. 776 and S. 801 represent two steps that are fiscally beneficial, publicly supported, and morally necessary. APHA therefore strongly supports both of these bills as stepping stones to the ultimate goal of a smoking-free society by the year 2000.

REFERENCES

Coalition on Smoking OR Health. *Fact Sheet on Increasing the Federal Excise Tax on Tobacco Products.* Washington, D.C., 1990.

Gallup. *Survey of attitudes towards various new taxes.* Conducted for the Coalition on Smoking OR Health, Washington, D.C.: Gallup Organization, 1989.

McAlister, Alfred, et al. *Cigarette Taxes for Public Health.* Houston, Texas: University of Texas School of Public Health, 1990, p. 6.

Schiffman, James R. After Uptown, Are Some Niches Out? *The Wall Street Journal,* January 22, 1990, p. B1.

Texas Poll. Conducted by the Public Policy Resources Lab at Texas A&M University, sponsored by Hartke-Hanks Communication, Inc., 1983.

U.S. Department of Health and Human Services. *Reducing the Health Consequences of Smoking: 25 Years of Progress. A Report of the Surgeon General.* U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. DHHS Publication No. (CDC) 89-8411, 1989, pp. 160, 298, 501-506.

U.S. Department of Health and Human Services. *Smoking and Health, A National Status Report.* U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Chronic Disease Prevention arid Health Promotion, Office on Smoking and Health, 1990, Table 6.

U.S. Federal Trade Commission. *Staff Report on The Cigarette Advertising Investigation.* Washington, D.C., May, 1981, p. 4-17.

U.S. Government Accounting Office. *Teenage Smoking. Higher Excise Tax Should Significantly Reduce the Number of Smokers.* Washington, D.C.: GAO, June 1989, GAO publ. no. HRD-89-119, p. 31.

Warner, Kenneth E. Smoking and health implications of a change in the Federal excise tax. *Journal of The American Medical Association* 255(8) 1986, p. 1028-1032.

NATIONAL CHAMBER FOUNDATION (NCF),
Washington, DC, June 11, 1990.

Hon. LLOYD M. BENTSEN, *Chairman,*
Senate Committee on Finance,
Washington, DC

Health Impact, Cost of Smoking

Dear Senator Bentsen: I am writing to submit the following comment for the 5/24/90 hearing record in the captioned matter. Nothing in this comment is intended to influence the passage of legislation now before the Congress of the United States.

The National Chamber Foundation ("NCF") is a 501(c)(3) tax and public policy research and education organization affiliated with the U.S. Chamber of Commerce. Foundation research is sponsored by interested business, individuals and academics. Our findings are available to more than 2,700 state and local chambers of commerce, 56 American chambers of commerce abroad, and more than 1,200 trade and professional affiliates of the Chamber of Commerce. Through BizNet, the Chamber's broadcast support facility, NCF research findings can be disseminated to more than 80% of the nation's television households.

Our purpose in submitting this testimony is to comment on recent and unfortunate trends in tax policy—namely the increasing reliance on highly regressive excise taxes and user-fees as revenue sources. Our concerns are that:

1. These revenue sources most adversely affect the working poor, the aged, women wage-earners, and the middle class.
2. State and local governments are increasingly reliant on excise taxes and user-fees. Given the decline of Federal revenue available for state and local activities, it can be expected that the states will look to these revenue sources and that adversely affected groups will be taxed twice.
3. User-fees have an accepted definition which is not reflected in recent proposals.
4. Excise taxes are inefficient allocators of Federal resources.
5. Revenue estimates tend to be overstated and fail to include the human cost of lost jobs and reduced economic growth.
6. Tax policy should not be used to advance social agendas.

BACKGROUND

By way of background, we note that our economy was not functioning smoothly in the late 1970s. Inflation was in double digits, interest rates were at an all time high and unemployment was outpacing the ability of state, local, and Federal Government assistance programs to ameliorate the misery. In some measure, President Reagan's election can be traced to poor economic conditions and based on this "mandate" the President moved quickly to cut taxes and government spending. The fundamental principle underlying the Reagan economic program was that every dollar left in the private sector was a dollar available for renewed economic activity.

Also at that time, the Congress was badly divided and without an economic agenda of its own. Absent some alternative—any alternative—the Congress accepted the President's call for tax cuts and passed ("ERTA") the Economic Recovery Tax Act of 1981. Unfortunately, Congress was not able to accept the spending restraint which necessarily had to follow on the tax cuts. Indeed, and based on persistent deficits, Congress has yet to come to terms with the need to reduce spending.

President Reagan's signature of ERTA had but dried when Congress recognized that the blueprint also called for spending restraint. The dilemma then became how to fund politically popular programs. The solution was a wink and nod between Congressional leaders and the White House; provided that rates and indexing were left alone, the President would sign a revenue bill.

The Senate took the lead and passed TEFRA—the Tax Equity and Fiscal Responsibility Act of 1982. To mask the apparent policy reversal and to secure the President's support for what otherwise was a revenue bill, Congress sold the act as a "reform" measure—one that put an end to abusive practices, closed loopholes, and denied unintended benefits. The success of this rally and call led in time to the passage of the Deficit Reduction Tax Act in 1984, and the Tax Reform Act of 1986. By 1986 the business community had given back every dollar of tax benefit enacted in 1981 and had sweetened the pot by some $300 billion.

Wittingly or not, Congress had created a money machine. By lowering rates and expanding the tax base it had an easy way to raise revenue. Many observers believe that Congress would have raised rates long ago had it not been for Presidents Reagan and Bush's solemn assurances to oppose "tax increases."

The revenue dilemma of the 1980s followed us into the 1990s. By now, however, Congress was not able to raise money by closing loopholes and ending abusive practices. A new blueprint was needed.

The new blueprint preserves the sanctity of rates but nonetheless increases the tax burden by raising money through excise taxes and user-fees. Although such revenue enhancers represent the poorest policy choice available, they supply the 90s blueprint with the incomparable virtue of appearing to be politically safe. Pursuant to this strategy more than $8 billion in new taxes slipped quietly into law in January of this year and the President asked for, and is likely to get, another $14 billion in such revenue in the next fiscal year.

In its annual effort to measure the tax burden on the average worker's paycheck, the Tax Foundation reports that Tax Freedom Day—the date when the American taxpayer will have earned enough money to pay this year's total taxes—is two days later than last year and fell on May 5, 1990. This means that the average taxpayer will labor 125 days, from January 1 to May 5, to satisfy all Federal, state and local tax obligations. The Tax Foundation attributes the two-day advance to several important factors: the base broadening provisions in the Tax Reform Act of 1986, the January 1, 1990 increase in the Social Security taxable earnings base and tax rate, and the slowdown in economic growth. Nominal income is estimated to grow only 5.7 percent in 1990 while the total tax take is projected to increase 7.2 percent. Simply stated, tax increases are outpacing the growth in individual income.

EXCISE TAXES ARE REGRESSIVE AND MOST ADVERSELY AFFECT THE ELDERLY AND WORKING POOR

Excise taxes and misapplied user-fees are, simply put, bad policy. They are regressive taxes in that they are levied without regard to one's ability to pay and they most adversely affect the working poor, the elderly, and working women.

In its 1988 report analyzing proposed excise tax increases totalling $18 billion, Peat Marwick Main & Co. found that the taxes of low-income taxpayers would increase and would substantially more than offset the income tax reductions contained in the Tax Reform Act of 1986. The following table compares the distributional effect of an $18 billion increase in excise taxes to the reduction in income taxes enacted in the Tax Reform Act of 1986. It shows that, for families with incomes of less than $10,000, the excise tax increase is nearly 5 times as great as the income tax reduction.

COMPARISON OF ENACTED INCOME TAX REDUCTIONS AND POTENTIAL EXCISE TAX INCREASES

Income Class (Thousands of dollars)	Income Tax Reduction	Excise Tax Increase (Millions of dollars)	Net Tax Change (Millions of dollars)	Excise Tax Increase as a percent of Income Tax Reduction
Under 10	-$414	$1,981	+$1,568	479
10-20	-2,983	2,653	-329	89
Subtotal	-3,397	6,635	+1,238	136
20-30	-3,319	2,836	-483	85
30-50	-8,112	5,366	-2,746	66
50-100	-7,609	4,324	-3,284	57
Subtotal	-19,040	12,526	-6,513	66
100-200	-3,572	610	-2,693	17
Over 200	-9,689	229	-9,460	2
Subtotal	-13,261	839	-12,423	6
Total	-35,698	18,000	-17,698	50

Source Peat Marwick Main & Co

These findings confirm those of prior studies showing that excise taxes disproportionately affect lower income wage-earners. Donald Phares, in 1980, analyzed the distributional impact of all major state and local taxes and found that the effective tax rate on excise taxes declines sharply as income rises.

A second and more recent study, prepared by the Congressional Budget Office, examined the distributional effects of major Federal excise taxes. The distributional

effects were measured relative to a broad-based definition of family income and to total family expenditures. The distributional estimates were based on the income and expenditure data in the 1982-1983 Consumer Expenditure Survey. Here again, the study found that excise tax rates decline sharply as incomes rise.

EXCISE TAXES AND USER-FEES ARE IMPORTANT STATE AND LOCAL REVENUE SOURCES

As Congress looks to excise taxes and user-fees, so do the states. Many local government officials have indicated that they will raise taxes or user-fees in order to address growing fiscal pressures.

The National League of Cities ("NLC") surveyed 314 municipal officials in November and December, 1989 and found that almost 40 percent expect to raise local taxes in the coming year and about 50 percent projected hikes in user-fees.

It should be noted that almost one-half of the NLC respondents judged Congressional handling of the budget deficit as a "total failure." They also gave grades of "poor" to "fair" for the Federal government's performance on drugs, poverty, waste disposal, homelessness, housing in general, education and oversight of financial institutions. Given these results, perhaps Congress should take a "go slow" approach when it comes to meddling with state and local government revenue sources.

NCF notes that over the past ten years, the amount of Federal revenue shared with local governments has declined by almost 50 percent in terms of real purchasing power. State aid to local governments has been growing in real terms but not fast enough to make up the difference. From 1979 to 1987, intergovernmental revenue as a percent of total local government revenue fell steadily from 45 to 38 percent. Given the current and projected state of the Federal budget, deficit reduction efforts are likely to result in more cuts in Federal aid to local governments and more pressure on state and local taxes.

USER-FEES ARE CHARGES FOR INDIVIDUAL CONSUMPTION OF PUBLIC SERVICES

A review of public finance literature shows that the term "user-fee" has an accepted definition—it is a charge levied on individuals who consume a service provided by government. Defined in this way, a user-fee represents a method of charging individuals directly for the public services they consume. A good example is given by the now common practice of charging entry fees to national parks. Such fees are true user-fees because, like market-determined prices, they help ration scarce resources and, moreover, they are levied not on the public at large but instead only on those who wish to consume the amenities offered by our system of national parks.

Under some circumstances, imposing a tax on a privately produced good can serve as a (usually imperfect) substitute for a user-fee. Consider the Federal excise tax on gasoline. In this case, an individual's tax liability obviously depends on his or her consumption of gasoline, but as long as gasoline consumption is a reasonable surrogate for the individual's consumption of the services of public highways, the gasoline tax can plausibly be thought of as a users' fee. It must be kept in mind, however, that this usage of the language of public finance is only partially correct. The user-fee terminology ignores the fact that the burden of the tax falls more heavily on individuals who drive "gas guzzlers" than on those who drive more fuel-efficient vehicles, even if the two groups of drivers consume the same amount of highway services. It also fails to account for the fact that insofar as rush-hour drivers impose congestion costs on other users at that time, the value of highway services is not uniform throughout the day. Thus, the connection between gasoline taxes and user-fees is imperfect, but making the connection can perhaps be excused because there is at least some direct correlation between consumption of the good that is taxed and consumption of a public service.

There is absolutely no excuse for referring to any part of the proceeds from the Federal excise taxes on alcohol and tobacco as user-fees, however. What public services do drinkers and smokers consume—that others do not—that equity considerations dictate they must help pay for? In recent years it has become fashionable to assert that consumers of alcohol and tobacco require more medical treatment than others, thereby creating the illusion that excise taxes on these goods can be represented as health care user-fees. But, this is such a misapplication of the language of public finance that it robs the term user-fee of any meaning whatsoever.

Content analysis of major news reports finds the often-repeated but erroneous suggestion that smokers are less productive than other employees. The *National Chamber Foundation* examined this assertion in its 1989 report entitled *Determinants of Employee Absenteeism* and found that single factor explanations of employee absenteeism and productivity are grossly misleading and not supportable.

The study analyzes the data on work loss collected in the National Health Interview Surveys for 1983 and 1985 by the National Center for Health Statistics. When all of the variables included in the study are analyzed simultaneously—gender, age, race, marital status, family income, and education—much of the conventional wisdom concerning absenteeism cannot be supported. Using a probit [1] analysis, only family income proved to have a statistically significant effect on absenteeism, higher levels of family income being associated with a reduced frequency of absenteeism. None of the other variables had any significant impact on worker absenteeism.

Three lifestyle variables—the individual's level of physical activity, consumption of alcoholic beverages, and consumption of tobacco products—were included in the analysis in an attempt to increase its predictive power. Only the first of these, the individual's level of physical activity, proved to be significantly associated with absenteeism, with higher levels of physical activity operating to reduce the frequency of reported absenteeism. The two additional variables—consumption of alcohol and tobacco products -proved to have no significant effect on absenteeism.

These findings are confirmed by soon to be released National Wine Coalition research showing that responsible drinkers of alcoholic beverages are much more likely to be in the labor force and at work than the general population—70 percent versus 62 percent. The study is entitled *New Perspectives on Wine Consumption and Human Behavior* presents findings based on 23,000 survey questionnaires compiled by the National Center for Health Statistics, an agency of the U.S. government. It goes on to note that individuals who consume alcohol are no more likely to miss a day of work because of illness than the general population. Wine-only drinkers reported a probability of work loss equal to or lower than the general population, which includes a substantial percentage of non-drinkers, in practically every age/gender breakdown. The study concludes that those who drink in moderation are indistinguishable from the rest of society when it comes to family and job-related issues, and in certain areas, such as worker absenteeism, are more likely to be at work than the average American.

In short, we have a solution without a problem. So characterized, proposals to raise excise taxes on tobacco and alcohol in order to promote a social good fail to survive scrutiny. Accordingly the underlying agenda is stripped of any relevant social goal and is left as a bald revenue enhancement measure.

Nor do these measures survive scrutiny as user fees.

With respect to alcohol and tobacco user-fees, the question becomes what, if any, Bureau of Alcohol Tobacco and Firearms services are demanded by tobacco growers, cigarette manufacturers, tobacco wholesalers, retail establishments, or consumers of cigarettes? Would any of these want to purchase any such service or pay for any such activity if provided by a private commercial enterprise? If so, would they be willing to pay anything like the present amount of the cigarette excise for the service or activity?

If not, then these fees are reduced to nothing more than revenue items of a highly regressive nature. If we are to raise taxes to reduce the deficit, it is because we believe deficit reduction is necessary for the economy as a whole. Certainly no one would argue that we should reduce the deficit merely to improve the economic condition of producers and consumers of cigarettes and alcoholic beverages. If there is merit in the argument that the deficit injures the economy, reducing the deficit must benefit everyone, not merely selected groups in the economy. If the deficit is to be reduced by raising taxes, everyone should assume the burden of tax increases.

EXCISE TAXES AND USER-FEES ARE INEFFICIENT ALLOCATORS OF FEDERAL RESOURCES

Even when properly levied, excise taxes and misapplied user-fees that go to trust funds ear-marked for specific expenditures are bad tax policy. Presently there are 11 such funds, including several transportation funds, several environmental quality funds, and a handful of miscellaneous funds such as the Black Lung Disability Trust Fund.

Indiana University professor John L. Mikesell examined these funds and reports that in each case the basis of the tax is not tightly associated with the need to provide the government service in question. In his words "these taxes do not serve as quasi-prices, increasing the efficiency of allocation of public services."

Mikesell also examined the role of the funds in the budget process under Gramm-Rudman-Hollings and concluded that they failed to serve a useful budgetary func-

---

[1] A unit of measurement of statistical probability based on deviations from the mean of a normal distribution.

tion. Indeed, the use of earmarked funds may prevent allocation of government funds to their most efficient uses. Finally, Mikesell says that "selective excises generally have little support as a revenue source," and are subject to criticisms including "discrimination according to taste, economic distortion, high collection cost, and low yield."

REVENUE ESTIMATES ARE INACCURATE

Congress, in 1988, was told that excise taxes on alcohol and tobacco would generate an estimated $21.5 billion. Congress was not told, however, that this revenue would be purchased at the expense of 3,000 jobs and $220 million in GNP in the tobacco industry and 8,500 jobs and $375 million in GNP in alcohol in beverage production. This type of static revenue estimation, though typical in government, is most misleading.

The National Chamber Foundation, in a recently released study of the impact of revenue driven tax legislation on equity markets, found that static revenue estimating techniques are most unreliable. The study *The Tax Treatment of the Dividends Received Deduction* concluded that Joint Committee revenue estimates are off by at least 60 percent, and may actually cost the Treasury $1.18 for every dollar Congress was told to expect.

On a larger scale, it should be noted that revenue projections given Congress in its consideration of the Tax Reform Act of 1986 have not been met.

CONCLUSION

Undoubtedly, in the coming months the Senate Committee on Finance will be presented with a litany of new "excise taxes" and "user-fee" proposals. NCF is concerned that the Committee will be lulled into adopting revenue measures ostensibly to promote some social good. Already, special interest groups are advocating higher environmental taxes to discourage pollution, increased alcohol and tobacco excise taxes to discourage use of these commodities, a quadrupling of the cost of transferring securities, an increase in gasoline taxes, etc.

Whatever the merits of the agenda underlying such proposals, the tax code is not the place to accomplish it. This is particularly true where, as here, the agenda is masquerading as a misguided attempt to raise revenue in a politically neutral way. Such disingenuous activity has a cost, and that cost is in employment and economic growth.

NCF appreciates this opportunity to submit comments on the record for the May 24, 1990 hearing on the health costs of smoking and would be pleased to provide additional information.

Yours truly,

ROBERT ALLEN RAGLAND, *Chief Tax Counsel.*

SOUTHERN LEGISLATIVE CONFERENCE,
Atlanta, GA, May 21, 1990.

Hon. LLOYD BENTSEN, *Chairman,*
Committee on Finance,
U.S. Senate,
Washington, DC.

RE: Written Statement for Hearing on the Health Impact, Costs of Smoking—Thursday, May 24, 1990—Dirksen Senate Office Building.

Dear Senator Bentsen: It is an honor to provide this written statement. The Southern Legislative Conference of The Council of State Governments, to date, does not have a policy position regarding the actual or perceived health effects of smoking on primary or secondary participants. However, we strongly support policies designed to ensure the health of infants and families. (Please note the attached policy position).

In addition, the southern states are particularly concerned about the escalating costs of basic health care, which have increased dramatically over the past decade, particularly those costs associated with infants born prematurely or of low birthweight.

While providing a means for meeting the basic health care needs of its citizens is critical to the future of the South (which experiences the highest infant mortality rate in the nation), we are equally concerned about adequately funding these basic health programs through the most equitable and progressive means available to our

legislative leaders. Although revenue sources are limited, we do not feel comfortable with using other sources (e.g., excise taxes) as a potential source of revenue to fund our health care needs. (Please note our policy position opposing increases in Federal excise taxes.) It states, in part, that excise taxes in general are regressive and increasing them at the Federal level would cause further revenue losses at the state level and also negatively impact on families living on low or fixed income. In short, even less money would be available to meet the basic health care needs if these individuals have to face additional tax burdens (particularly from excise taxes).

I appreciate the opportunity to give this written testimony. If the Southern Legislative Conference can be of any further help to you or other members of the Senate Finance Committee, please feel free to let me know.

Sincerely,

COLLEEN COUSINEAU, *Executive Director.*

Attachment.

POLICY POSITION—OPPOSING INCREASES IN FEDERAL EXCISE TAXES

Background

State excise tax revenues have been significantly reduced as a result of Federal excise tax increases on gasoline, tobacco, and distilled spirits. States rely more heavily on indirect taxation as a source of revenue and an increase in Federal excise tax rates have significant negative impacts on state finances generally.

Excise taxes in general are regressive and increasing them at the Federal level would cause further revenue losses at the state level and would also negatively impact on families living on low or fixed incomes. The states have assumed increasing burdens for Federal programs, in both funding and implementation, while maintaining constitutional requirements for balanced budgets.

State excise revenues have been a traditional source of state revenue since shortly after World War II. States rely upon sales-based taxes to a far greater extent than the Federal government. This reflects the Federal government's presumption of much of the income tax base, creating the necessity for the states' reliance on other sources of revenue.

The National Conference of State Legislatures presented a letter to President Bush on January 29, 1989, opposing increases in Federal excise taxes and Federal Government excise taxes and Federal Government excise tax increases which would encroach on traditional revenue bases of state government.

Revenue loss to the states from the last round of Federal excise tax increases is estimated to be $3.7 billion between 1983 and 1988, and total revenue loss to the states will be $7.2 billion from 1983 to 1992. Any Congressional Budget Resolution which would increase Federal excise taxes would represent an encroachment on a traditional source of state revenue.

Recommendation

The Southern Legislative Conference opposes increases in Federal excise taxes and urges the President of the United States, the Honorable George Bush, the United States Senate Finance Committee, the United States House Ways and Means Committee and, particularly, the Committee members from the states of the Southern Legislative Conference to preserve the spirit of tax reform and not adversely impact state fiscal systems, displace state revenues and reduce the flexibility of state tax policy.

Adopted by the Southern Legislative Conference July 19, 1989. (Sponsor: Representative Ron Cyrus, Kentucky.)

STATEMENT OF MIMI WORTH

I believe that some U.S.A. babies are not getting their rights!!

If mothers smoke during pregnancy, the result is NOT a good one!! The child could turn out to be mentally retarded!! In some cases the children even DIE at birth!!!

No, it is NOT fair to babies for mothers to smoke. It is pitiful to do so! Very pitiful!!

If you have not caught on to the point yet, I will tell you.

The point is that it is definitely NOT fair to babies for mothers to smoke during pregnancy! They have a right to live just like you and I do!!

An idea I might suggest is that the government should give a mother $100.00 tax refund (or something like that) if she does not smoke (or use alcohol) while she is pregnant. Maybe her doctor could prove this

In the state of Oregon, at the very, very, very, very most, this sum would add up to $4,000,000 per year.

I figure that is much less than the cost to take care of all the mentally retarded or damaged children born each year

Thank you!

35-777 (196)