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The Alaska Tobacco Control Program

A PLAN FOR THE FUTURE

prepared by the

Alaska Tobacco Control Alliance

March 5, 1999

This Plan for the Future is dedicated to the memory of Dorris Ann Brewer of Soldotna, Alaska, shown here with her granddaughter, Olivia. Dorris died of complications from emphysema on June 29, 1997. She was 59 years old.

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"The scientific evidence shows us that price increases coupled with the implementation of effective tobacco control programs can dramatically reduce the use of tobacco products. Alaska has led the way with increasing the price of tobacco products, and now has the opportunity to put in place proven tobacco prevention programs."

Michael Eriksen, M.D.
Director, Office on Smoking and Health
Centers for Disease Control and Prevention

INTRODUCTION

Formed in 1992, the Alaska Tobacco Control Alliance (ATCA) is a statewide coalition of organizations and individuals working to reduce the leading cause of preventable death in Alaska—tobacco use.

While tobacco prevention and control activities have increased since ATCA was initially formed, current efforts fall far short of what is needed to effectively counter tobacco industry tactics and reach state and national goals for tobacco use reduction.

In 1996, the federal Centers for Disease Control and Prevention (CDC) estimated that 18,000 Alaskans currently under the age of 18 would eventually die prematurely from tobacco-caused disease. Passage of the 71¢/pack tobacco tax increase in 1997 led to a revised estimate of approximately 14,000 premature deaths—a 22% decrease. While the tobacco tax increase was an important first step, 14,000 deaths represents a staggering loss and one which Alaskans should not accept as inevitable. It should also be noted that the 14,000 estimated deaths does not include the future smoking-related deaths among Alaskan adults who currently smoke.

With the passage of the tobacco tax increase in 1997 and Alaska's settlement with the tobacco industry in 1998, state government will soon be collecting over $70 million annually from tobacco sources, yet the current state budget for tobacco control (general fund dollars) is only $200,000. (See bar graph on inside back cover.)

Both the State of Alaska and the U.S. Department of Health and Human Services have set a goal of reducing smoking prevalence to no more than 15%. Alaska's current smoking rate is 27%. Such a reduction can only be accomplished if we invest significant resources in tobacco prevention and cessation programs. The CDC has recommended a spending level for Alaska of $8.7 to $17.7 million to achieve a 44% reduction in smoking prevalence and similar reductions in smokeless tobacco use.

This plan outlines a comprehensive, long-term program for reducing tobacco-caused addiction, disease, and death. It calls for a broad-based collaborative effort involving state and local policy makers, the professional health care community, businesses, educators, parents, and children. It incorporates strategies proven to be effective in fighting the tobacco epidemic.

Success will require resources and partnerships including both the public and private sectors. To significantly reduce tobacco use and decrease the human and economic costs, Alaska must institute a plan that will prevent children from becoming addicted, help youth and adults who want to quit, and protect non-smokers from secondhand smoke.

The goals are within reach. It is time to move ahead and achieve them.

ATCA Steering Committee:

Alaska Council on Prevention of Alcohol and Drug Abuse
American Cancer Society, Western Pacific Division
Alaska Dental Society
Alaska Department of Health and Social Services
American Heart Association - Alaska Affiliate
Alaska Health Fair, Inc.
Alaska Native Health Board
Alaska Native Medical Center
Alaska Public Health Association
Alaska State Medical Association
American Lung Association of Alaska
Anchorage School District
Bristol Bay Area Health Corporation
KD Consulting
Municipality of Anchorage, Department of Health and Human Services
Nome Community Center - Young Teen Center
Rural Alaska Community Action Program
Sitka Prevention and Treatment Services
Southeast Alaska Regional Health Consortium
Tanana Chiefs Conference

HEALTH IMPACTS OF TOBACCO

SINCE THE FIRST U.S. SURGEON GENERAL'S REPORT on smoking and health was published in 1964, more than 10 million Americans have died from smoking-related causes.[1]

Nothing kills like tobacco.

- **Smoking is the leading cause of preventable death** in Alaska, as in the U.S. as a whole.[2]
- **Tobacco is responsible for one out of five deaths** in Alaska, or almost 500 deaths a year. From 1992-1994, smoking accounted for 19.8% of all deaths in Alaska.[3]
- **Almost 14,000 Alaskans under the age of 18 alive today** will eventually die from tobacco-caused illness unless current trends are reversed.[4]
- **Smoking kills half of all long-term users** and half of those people die in middle age from a variety of diseases including heart disease, lung cancer, other cancers, and respiratory illness.[5]
- **Almost all smokers first become addicted as children.** The average age of new smokers is 14.5.[6]
- **Smoking is not just a problem for smokers.** Secondhand smoke, also known as environmental tobacco smoke (ETS), is a significant cause of disease and death in non-smokers.

TOTAL NUMBER OF DEATHS AND ESTIMATED SMOKING-RELATED DEATHS IN ALASKA, 1992-94[9]

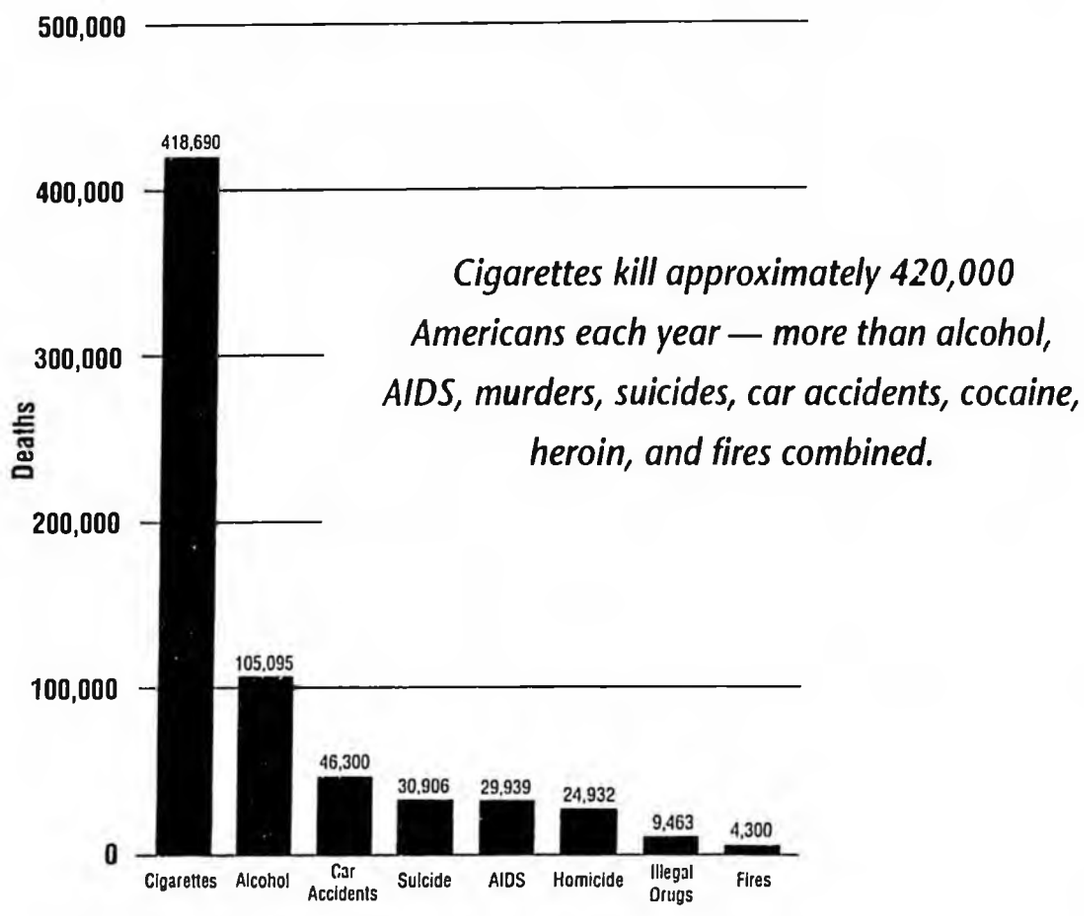
Cause of Death	Total # of Deaths	Smoking Related Deaths	Percent Smoking Related
Cardiovascular	2,010	533	26.5%
Cancers	1,655	546	33.0%
Respiratory	503	260	51.7%
Perinatal (<12 mos)	204	14	6.9%
TOTAL	7,159	1,416	19.8%

- **Secondhand smoke is the third leading cause of death** in this country, behind active smoking and alcohol abuse.[7]
- **The disease caused by tobacco use takes many forms.** Deaths related to cigarette smoking include a portion of cardiovascular disease; cancers of the lung, larynx, oral cavity, esophagus, pancreas, bladder, kidney, and cervix; chronic bronchitis, emphysema, and other respiratory deaths.[8]

HEALTH IMPACTS OF TOBACCO

- **Cigarettes kill approximately 420,000 Americans each year** — more than alcohol, AIDS, murders, suicides, car accidents, cocaine, heroin, and fires combined.[10]

- **Smoking can cause spontaneous abortion** in pregnant women who smoke, as well as premature birth and low birth weight infants. Maternal smoking can play a role in Sudden Infant Death Syndrome (SIDS).[11]



Source: Centers for Disease Control and Prevention, U.S. Dept. of Health and Human Services, 1990 data.

HEALTH IMPACTS OF TOBACCO

- **Secondhand smoke or environmental tobacco smoke (ETS)** causes cancer, heart disease, asthma, and other illnesses in non-smokers.[12]

- **Estimates of total annual deaths from ETS in the United States range from 40,036 to 76,912 with a mid-range estimate of 53,974.**[13] This means that for every eight smokers killed by tobacco, one non-smoker dies too.

- **In Alaska, that means about 60 people die each year** from illness and disease caused by secondhand smoke.

"Tobacco products are the cause of major morbidity and mortality among humans from the time of conception onward... At least three times as many infants die of SIDS caused by maternal smoking as are killed as a result of homicide or child abuse."

Joseph R. DiFranza, M.D.
University of Massachusetts

- **The effects of exposure to secondhand smoke are especially severe in children.** Respiratory health effects of ETS exposure in children include middle ear infections, asthma, bronchitis, and pneumonia. At least 6,200 children die each year in the U.S. because of their parents' smoking.[14]

- **Cigar smokers have similar death rates from oral, laryngeal, and esophageal cancers as do cigarette smokers** and face increased risk of lung cancer and chronic obstructive lung disease compared to non-smokers.[15]

- **Smokeless tobacco causes cancers of the mouth and pharynx** and may play a role in other cancers.[16]

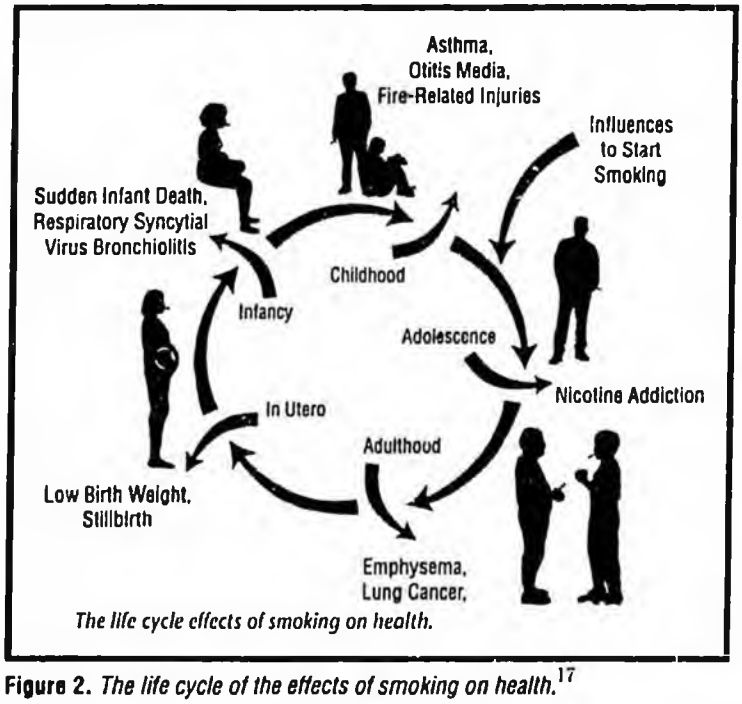


Figure 2. *The life cycle of the effects of smoking on health.*[17]

TOBACCO USE & NICOTINE ADDICTION

Tobacco addiction is a "pediatric disease."

Alaska has one of the highest smoking rates in the country with an adult smoking prevalence of 26.5%.[18] Eighty percent of those smokers report that they want to quit.[19]

- **Tobacco addiction is described as a "pediatric disease" because addiction nearly always starts in childhood** — 89% of smokers start before age 19 with 14.5 as the average age of initiation.[20] In Alaska, 84% of adult smokers report having started before between the ages of 10 and 20.[21]

- **Each day nationwide, some 3,000 youth under age 18 become daily smokers.**[22] These young people are targeted by the tobacco industry to replace the hundreds of thousands of adults who die or quit each year.

- **Smoking among high-school seniors in the U.S. is at a 19-year high.** The number of American teenagers taking up smoking as a daily habit jumped 73% between 1988 and 1996.[23]

- **Tobacco appears to be a "gateway drug" for teenagers.** Teens who smoke are far more likely than their nonsmoking peers to use other drugs.[24]

- **The 1995 Youth Risk Behavior Survey (YRBS) found 36.5% of Alaskan high school students were "current smokers,"** having smoked one or more cigarettes in the past 30 days, and 21.1% were "frequent smokers," having smoked on at least 20 of the last 30 days.[25]

TOBACCO USE AMONG HIGH SCHOOL STUDENTS, 1995

	Alaska	Alaska Native	U.S.
Current Smokers	36.5%	61.9%	34.8%
Frequent Smokers	21.1%	43.7%	16.1%
Smokeless Tobacco	15.6%	22.5%	11.4%

- **The 1995 YRBS also found that 15.6% of Alaskan high school students used smokeless tobacco,** including 22.5% of Alaska Natives students.

TOBACCO USE & NICOTINE ADDICTION

- **What starts as an experiment by youth soon becomes a long-term addiction** with 70% of adolescent smokers wishing they had never started smoking in the first place.[26]

- **The U.S. Surgeon General's office reports that nicotine dependence is the most common form of drug addiction** and one of the most difficult to overcome. Researchers widely regard nicotine to be as addictive as heroin or cocaine.[27]

"Well, do you think I chose to smoke? Do you believe that I took a cigarette and said, 'I think I'll smoke this one and then maybe four hundred thousand more?' "

47-year old smoker speaking of addiction
as reported by Dr. David Kessler

- **Of the 20 million Americans who try to quit smoking each year,** only 3% have long-term success.[28]

- **Some cessation strategies have proven successful** in helping smokers quit, including behavioral counseling, nicotine replacement therapy, the prescription drug bupropion, and encouragement from doctors.[29] A combination of these strategies can boost 1-year success rates above 50%.[30] However, these strategies are currently underutilized.

- **Limited information about options, the expense of cessation services, and lack of insurance coverage** often hampers tobacco users who want to quit but do not know how to effectively overcome their nicotine addiction.

Alaska Natives suffer 23.2% of smoking-related deaths, although Natives comprise only 16.5% of the state's population. The disproportionate impact of tobacco use on Natives is due to extremely high rates of tobacco use in the Native population (45.1%).[31]

ECONOMIC IMPACTS OF TOBACCO USE

"It's time to make smoking history."

In addition to the human suffering from disease and death, tobacco burdens all members of society with economic costs associated with preventable health care expenditures and lost worker productivity.

- **Current and former smokers in the U.S. generate over $500 billion in excess health care costs** over the course of their lives,[32] even though smokers die an average of eight years younger than non-smokers.[33]
- **Total medical expenditures attributable to smoking amount to over $70 billion a year in the U.S.** In Alaska, total medical expenditures attributable to smoking are estimated at $154 million annually.[34] Of this total, Medicaid pays $23.6 million.[35]
- **The total state and federal tax burden from tobacco-caused health costs in Alaska** is estimated to be $70 million a year, or $320 a year per household.[36]
- **Tobacco use also impacts the economy through lost worker productivity** due to illness and early death. These costs are borne largely by Alaskan employers.

MEDICAL COSTS ATTRIBUTABLE TO SMOKING IN ALASKA

Total annual health care expenditures in Alaska directly related to smoking	$154,000,000
Total annual state Medicaid payments directly related to smoking	$23,600,000
Additional expenditures in Alaska for health and developmental problems of infants caused by their mothers' smoking or being exposed to secondhand smoke during pregnancy[37]	$8,000,000

THE TOBACCO INDUSTRY

As a public health threat, tobacco use is distinct not only by virtue of the staggering magnitude of the disease and death caused by the product, but also because of the powerful industry that profits from tobacco use. Tobacco is the only consumer product that kills when used exactly as intended, yet it is also one of the least regulated products.

"The difference between malaria and tobacco is that mosquitos don't hire PR firms and make campaign contributions."

Stanton Glantz, MD
University of California, San Francisco

- **Nicotine addiction is big business.** The industry spends $5 billion a year on advertising and promotions alone, averaging $13 million a day.[38]

- **Studies show that youth are more influenced by tobacco advertising than are adults.** For example, the three most heavily advertised brands of cigarettes (Marlboro, Camel, and Newport) are preferred by 86% of underage smokers but only 35% of adult smokers. Marlboro, the most advertised brand, constitutes about 60% of the youth market but only about 25% of the adult market.[39]

- **According to the CDC, youth oriented advertising and promotional campaigns have played a key part in the sharp increase in youth smoking rates** since Joe Camel made his debut in 1988. Youth smoking is currently at a 19 year high.[40]

- **While tobacco companies say that they don't want kids to smoke,** they have fought with tremendous resources to defeat all serious efforts to reduce youth tobacco use. The defeat of anti-tobacco legislation in Congress (the "McCain bill") is a recent example.

"Today's teenager is tomorrow's potential regular customer."

1981 Philip Morris internal document

- **In spring 1997, R.J. Reynolds sent a spokesperson to Alaska** to try to persuade legislators that a tobacco tax increase would lead to a huge smuggling problem. In December 1998, an R.J. Reynolds affiliate pled guilty to federal criminal charges stemming from a scheme to smuggle untaxed cigarettes into Canada.[41]

THE TOBACCO INDUSTRY

- **When other dangerous consumer products, drugs and health threats** such as DDT, asbestos, and PCBs have been brought under strict regulation, why has so little progress been made to reduce the disease and death caused by tobacco? The answer lies in the tobacco lobby's extraordinary economic and political power. Tobacco is so addictive and so profitable, it yields billions of dollars in profits a year—a massive treasury to fuel a multifront war against the underfunded forces of public health.

"Leave it to the tobacco industry to call inhaling 43 known carcinogens refreshing."

message on poster
California Dept. of Health Services

- **In its successful bid to kill comprehensive tobacco control legislation in Congress in 1998,** the industry hired one lobbyist for every two and a half members of Congress and spent $40 million on the most expensive political advertising campaign ever undertaken on a piece of pending legislation. Independent analysis by the Annenberg Public Policy Center described statements in the industry ads as "false," "misleading," and "deceptive."[42]

Profits premised on addiction, resulting in disease and death.

- **Tobacco companies use their huge profits to promote their products. Messages to use tobacco are visible everywhere,** even in remote Alaska, where Marlboro, Camel, and Winston logos are found on caps, bags, and shirts—items that are particularly appealing to youth.

- **In public statements, the tobacco industry has long denied that tobacco is addictive,** even in sworn statements to Congress. However, internal company documents reveal that the industry has known about the addictive properties of nicotine for decades.[43]

- **Tobacco company documents disclosed in litigation revealed industry efforts to skew the scientific record** by paying scientists to write letters to journals questioning secondhand smoke as a cause of cancer. The industry paid 13 scientists more than $156,000 to write letters to prominent journals and the Tobacco Institute paid $10,000 for a single letter.[44]

A VISION FOR THE FUTURE: ELEMENTS OF A STATE PLAN

Healthy People 2000 national objectives and Healthy Alaskans 2000 objectives both call for reducing smoking prevalence to no more than 15% in youth and adults. This is a huge challenge in a state with one of the highest smoking rates in the nation. Smokeless tobacco use is also a serious problem in Alaska.

"The most important public health issue of our time."

C. Everett Koop, MD

To significantly reduce tobacco use and decrease the human and economic costs, Alaska must establish and fund a comprehensive plan that will:

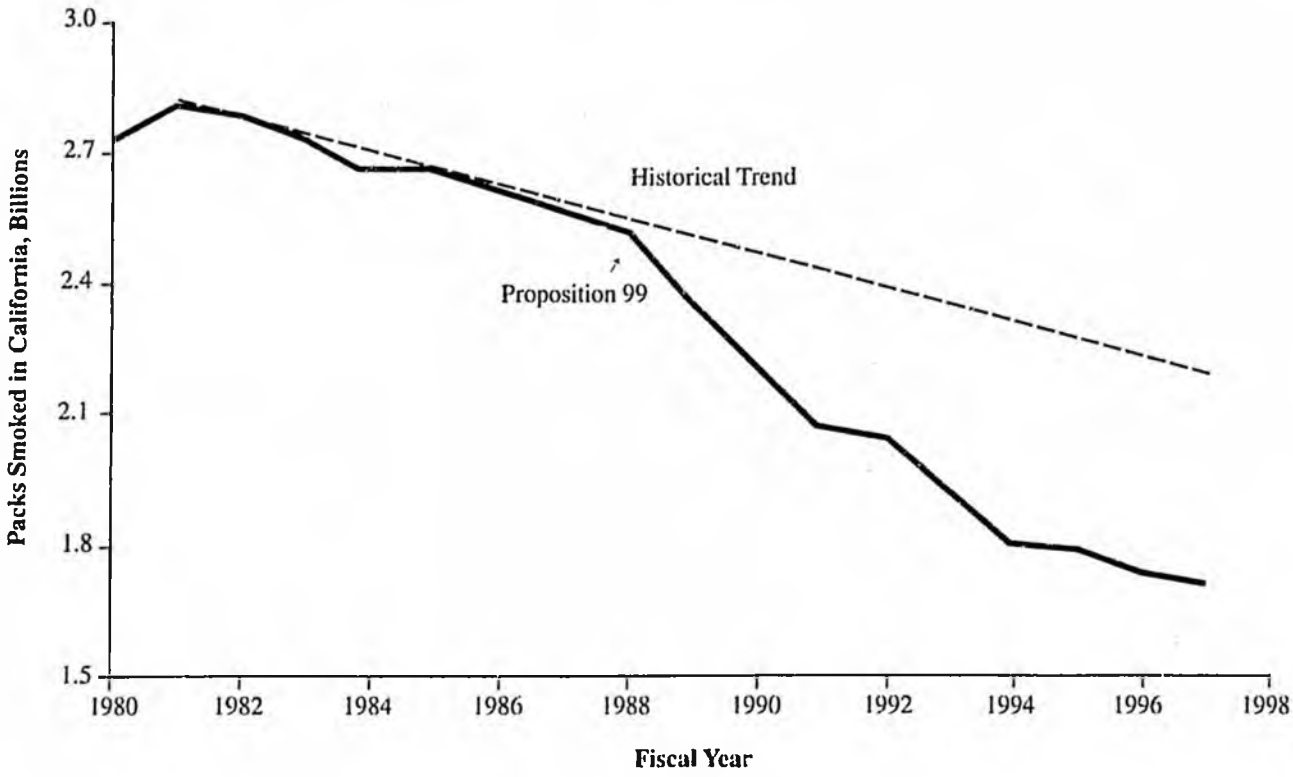
- prevent children from becoming addicted,
- help youth and adults who want to quit, and
- protect nonsmokers from secondhand smoke.

Experts agree there is no "magic bullet" that will quickly change social norms about tobacco use and end the tobacco epidemic. All elements of a comprehensive strategy must be supported. The most effective and efficient program will utilize a coordinated, decentralized approach that puts the great majority of resources into communities and organizations outside of state government.

Such an effort must involve kids, parents, teachers, health workers, law enforcement personnel, employers, and policy makers. Community-based projects, school-based projects, and state-of-the art cessation services are key components. Equally critical to the overall program is a sophisticated, high-profile statewide media campaign that will raise public awareness of tobacco issues and support other prevention and cessation efforts. Coordination, evaluation, and enforcement are other elements of a comprehensive tobacco control program.

Recently the Centers for Disease Control and Prevention has assisted states by developing program and funding guidelines for comprehensive state tobacco control programs. The CDC guidelines were developed through evidence-based analyses in California and Massachusetts, where large, comprehensive state programs funded with tobacco tax revenues have been in existence for several years. In these two states, per capita consumption of tobacco has declined more rapidly than in the rest of the country and tobacco use among youth has slowed in comparison to national trends. In California, cigarette consumption has declined more than 40% overall; Massachusetts has seen a 31% reduction in smoking since its program was implemented.[46]

DECLINE OF TOBACCO CONSUMPTION IN CALIFORNIA, 1980-1997[46]



In 1988, California voters approved a 25¢ per pack cigarette tax increase with 20% of the revenues dedicated to programs to reduce tobacco use. Since then, smoking consumption in California has declined by more than 40%.

A VISION FOR THE FUTURE: ELEMENTS OF A STATE PLAN

CDC recommends that states establish tobacco control programs that are comprehensive, sustained over time, and that utilize community partnerships. For Alaska, the CDC recommends $8.7 million per year as a minimum level of funding for an effective statewide program, with an optimum funding level of $17.7 million per year.[47]

In developing this plan for Alaska, Alaska Tobacco Control Alliance work group members studied the CDC guidelines, spoke with individual program people at CDC, consulted with experts in other states, considered the unique characteristics of our state, and built a plan "from the bottom up." That is, members identified the essential elements of a comprehensive program and then determined what it would really take to implement those programs in Alaska.

"We must not allow the past to become the future."

Work group members also understood the need to be pragmatic, particularly in light of the state's current fiscal challenge and other important needs confronting policy makers. For this reason, the budget for the Alaska Tobacco Control Program totals only $8.2 million – less than even the minimum funding level recommended by CDC. This figure represents only about 30% of the average annual payment to Alaska from the state's settlement with the tobacco industry.

In the words of one CDC official, there is a "dose-response relationship" between funding for tobacco control and reductions in tobacco use. That is, greater funding results in greater reductions. An annual funding level of $8.2 million should be thought of as the *minimum* needed for a comprehensive program in Alaska. Increased funding can be expected to result in larger and more rapid declines in tobacco use among youth and adults.

The following pages provide more detail on the seven central components of the Alaska Tobacco Control Program:

Community Programs	$2 million
Cessation Programs	$1.4 million
Countermarketing	$1 million
School-Based Programs	$750,000
Tobacco-Free Partnership Projects	$1.8 million
Enforcement	$600,000
Program Development, Management, and Evaluation	$650,000
TOTAL	$8.2 million

COMMUNITY PROGRAMS TO REDUCE TOBACCO USE

Community efforts to change public attitudes and behaviors about tobacco represent a key component in any comprehensive program to reduce tobacco addiction. Such efforts must involve as many community members as possible in planning and carrying out public awareness campaigns and other activities to promote tobacco-free social norms. Coordination and technical assistance will ensure that community partners are accountable for effective project implementation.

For example...

Community efforts could include:

- local coalitions of parents, youth, business people, religious leaders, health workers, and other concerned individuals implementing a campaign to encourage voluntary smoke-free home policies.
- efforts to encourage tobacco merchants to check ID and refuse sale to underage customers.
- peer training programs such as Teens Against Tobacco Use, in which teenagers serve as educators and role models for younger children.
- campaigns designed to reduce "social sources" of tobacco to minors (e.g., adults giving or buying tobacco for use by kids).
- efforts to increase the number of smoke-free workplaces and public places.
- community health fairs that include tobacco prevention and cessation information and workshops.
- special pilot projects to explore and evaluate innovative approaches for tobacco use reduction.

Costs and funding

A minimum budget of $2 million is recommended for Community Programs.

- Within this program, grants would be provided to non-profit organizations, local government agencies, local businesses, ethnic organizations, and other community partners.
- Approximately three-fourths of the funds would be used to support community coalitions in their efforts to address the three major areas of tobacco control (reducing youth initiation, protecting nonsmokers from ETS, and promoting cessation for youth and adults).
- Approximately one-fourth of the funds would be distributed as grants to conduct and evaluate pilot programs that are community or regionally based.

"When communities change their outlook and their policies about tobacco use it's more likely that tobacco users will be able to quit, and less likely that young people will begin using tobacco... Coalitions of community members are especially important when involved in efforts to change community norms."

from "Tobacco Prevention and Education Program Report - 1999"
Oregon Health Division

CESSATION PROGRAMS

The vast majority of smokers want to quit. Those who succeed greatly reduce their risk of smoking-related disease and early death. In addition, helping adults to quit smoking protects their children from the dangers of secondhand smoke and can reduce the number of newborn babies who suffer or die as a result of "passive smoking." Cessation programs that include counseling and pharmaceutical support can increase success rates dramatically. Other components of a statewide tobacco control program, such as community-based projects and a high profile media campaign, will help motivate smokers to take advantage of cessation services.

For example...

The following are characteristics of an effective tobacco cessation component:

- The program must include a statewide, toll-free "Quit Line" that allows callers to talk to trained cessation counselors. Up to six follow-up calls will be made to "quitters" to provide additional support during those critical early days and weeks.
- Callers with insurance coverage for cessation products (nicotine replacement therapy or bupropion) will be linked to providers. Callers without insurance coverage for cessation will be provided with appropriate cessation products free of charge.
- A systematic effort must be made to train health care providers (doctors, dentists, community health aides) in implementing the Clinical Practice Guidelines for smoking cessation developed by the federal Agency for Health Care Policy and Research.
- Success of the cessation component will be greatly enhanced by a strong marketing effort (e.g., paid media), referrals to the Quit Line by health care providers, and community campaigns to promote cessation.

Costs and funding

A minimum budget of $1.4 million is recommended for the Cessation Program.

- It is estimated that operation of a statewide Quit Line would cost $850,000 per year. In other states, contracts have been made with universities, HMOs, and non-profit health organizations to provide Quit Line services.
- Costs for pharmaceutical cessation products for Quit Line participants who do not have insurance coverage are estimated at $300,000.
- A statewide training program targeting health care providers could be funded with $250,000 through contract with one or more non-profit organizations.
- Paid media costs are included in the Countermarketing budget.

"As cigarette taxes and tobacco settlement dollars increasingly provide support for social and health care programs, it is morally imperative for us as a society to use a portion of this money to ensure that motivated tobacco users have easy access to proven help for quitting."

Tim McAfee, MD, Group Health of Puget Sound

COUNTERMARKETING

No one knows better than the tobacco industry the power of advertising and product promotion. Health advocates can use these same tools with powerful impact. Research shows that tobacco countermarketing promotes quitting, decreases the likelihood of initiation, and supports school and community efforts to create tobacco-free social norms.

For example...

A countermarketing campaign should include the following characteristics to be most successful:

- It must incorporate paid media, public relations, and special events and promotions in a coordinated effort that is integrated with the other elements of a comprehensive tobacco control plan.
- It must be well-funded so the media component can achieve the reach necessary to be effective. This effort must be sustained over the long term.
- There should be no restrictions on the content of the messages, and the campaign must operate completely independent of tobacco industry input.
- The campaign should include ads that expose tobacco industry tactics, hard-hitting messages about secondhand smoke, and messages that encourage smoking cessation and promote the Quit Line.

Costs and funding

A minimum budget of $1 million is recommended for a statewide countermarketing campaign.

- The countermarketing campaign will be implemented through one or more contracts with advertising/public relations firms.
- The countermarketing budget covers development of new ads for Alaska, payment of talent fees for ads developed in other states (available through the CDC Media Resource Center), and paid placement of ads on television, radio, in print formats, movie screens, and on public transit vehicles.

"A strong media campaign is a key element of any tobacco control effort... To compete with tobacco industry advertising, anti-tobacco advertisements need to be ambitious, hard-hitting, explicit, and in-your-face..."

Lisa Goldman and Stanton Glantz, University of California, San Francisco, describing results of their research on the effectiveness of paid antismoking advertising

SCHOOL-BASED PROGRAMS

While almost all children know that "smoking is bad for you," this fact alone has not prevented a dramatic increase in youth smoking since 1988. The Centers for Disease Control and Prevention has evaluated school-based tobacco prevention programs and issued guidelines for choosing and implementing an effective program. When these guidelines are followed, a school-based program can reduce smoking prevalence significantly.

For example...

CDC guidelines specify 7 critical components in an effective school-based program:

- tobacco-free policy for students and adults
- effective tobacco prevention curriculum in grades K-12, with special emphasis on middle school students
- training for school staff
- parent and family involvement
- linkage and coordination with local coalitions and communities
- cessation support
- evaluation of effectiveness

Student instruction should:

- decrease the social acceptability of tobacco use and show that most young people do not smoke.
- expose tobacco industry motives and tactics in encouraging youth tobacco use
- develop students' skills in assertiveness, goal setting, problem solving, and resisting pressure from the media and peers to use tobacco.

Costs and funding

A minimum budget of $750,000 is recommended for School-based Programs.

- Funds will be awarded directly to school districts on a competitive basis. Programs will be supported by statewide technical assistance through the Department of Education and the Department of Health and Social Services. (Funds to DOE will be passed through from DHSS.)
- Accountability is important. Based upon the experience of several states in funding school programs, CDC recommends that funds be awarded to school districts that have clearly-stated performance objectives consistent with CDC guidelines.
- The School-based Programs budget will cover the costs of training and technical assistance to school personnel, curriculum materials for students and teachers, and project staffing within the school districts. Curricula that might be used are Towards No Tobacco Use, Life Skills Training, Project Alert, Get Real About Tobacco, and the Alaska Community-Oriented Tobacco Project. Approximate cost per student is $7, to reach about 100,000 students.

"All funded school projects are working with community partners and local coalitions. Students are involved in visits to retailers to assure that they are checking ID and refusing to sell tobacco to youth... They participate in community education events and are involved in promoting smoke-free policies."

— from "Tobacco Prevention and Education Program Report - 1999"
Oregon Health Division

TOBACCO-FREE PARTNERSHIP PROJECTS

Within this component, a variety of external partners will expand project reach and impact by targeting at-risk populations, incorporating tobacco prevention and cessation efforts within other health programs, and providing critical networking, communications, technical assistance, and research services from outside the state bureaucracy. Like the Quit Line and counteradvertising campaign, these projects are statewide in scope.

For example...

Tobacco-free Partnership Projects could fund:

- prevention and cessation programs targeting special populations such as Alaska Natives, pregnant women, drug/alcohol treatment clients, and low income families.
- programs to include tobacco education in campaigns to reduce heart disease, asthma, and dental disease.
- enhanced networking through a statewide tobacco control website and newsletter.
- a statewide clearinghouse of tobacco control materials.
- statewide conferences for tobacco prevention and cessation training.
- statewide youth advocacy projects.
- research programs to evaluate the effectiveness of tobacco control interventions.

Costs and funding

A minimum budget of $1.8 million is recommended for Tobacco-Free Partnership Projects.

- Contracts would be awarded on a competitive basis to such groups as
  - professional associations (e.g., doctors, dentists, nurses)
  - non-profit health organizations
  - universities and research groups
  - public relations firms, communications firms, private contractors
- Contract awards might range from $50,000 to $200,000.
- A statewide Quit Line is included in the Cessation component. Likewise, the statewide Countermarketing campaign is a separate component within the comprehensive tobacco control program.

"An R.J. Reynolds planning document concluded that 'the California campaign, and those like it, represents a very real threat to the industry in the intermediate term...' "

from "A Model for Change: The California Experience in Tobacco Control"

ENFORCEMENT

Enforcement of tobacco control policies enhances their efficacy both by deterring violations and by sending a message to the public that community leadership believes the policies are important. Existing laws and new laws in the areas of youth access, tax compliance, and clean indoor air all require enforcement for maximum impact.

For example...

- Prior to 1997, Alaska's law prohibiting the sale of tobacco products to minors had never been enforced, and was widely ignored by merchants. In communities where police are now enforcing the law, compliance has improved dramatically (as measured by undercover compliance checks).

Other state laws currently requiring enforcement in Alaska include:

- a ban on self-service tobacco displays.
- restrictions on smoking in certain worksites and public places.
- restrictions on the placement of cigarette vending machines.
- the requirement that a state tax be paid on all tobacco purchases.
- the requirement of a special business license endorsement for merchants who sell tobacco.

Costs and funding

A minimum budget of $600,000 is recommended for the Enforcement component.

- Approximately $110,000 will be provided to the Alaska Department of Law, primarily for the enforcement of laws relating to youth access to tobacco.
- Approximately $110,000 will be provided to the Alaska Department of Revenue for enforcement of laws regarding payment of state tobacco taxes.
- Approximately $80,000 will be provided to the Alaska Department of Commerce for enforcement of laws relating to tobacco vendor licensing.
- Approximately $300,000 will be provided to the Alaska Department of Public Safety, to support local police departments in enforcing state tobacco control laws.

"The small body of evidence examining the effects of active enforcement on youth smoking suggests that it is an important and essential element of a comprehensive effort to reduce young people's use of tobacco. However, young people may turn to social sources (e.g., older friends and family members) of tobacco products as commercial sources are reduced. Therefore, it is critical that minors' access restrictions be combined with a comprehensive tobacco control program that reduces the availability of social sources and limits the appeal of tobacco products."

— from "Program and Funding Guidelines for Comprehensive Tobacco Control Programs," Centers for Disease Control and Prevention, January 1999

PROGRAM DEVELOPMENT, MANAGEMENT, & EVALUATION

Ultimate accountability for the wise use of state tobacco control program dollars must rest with the Alaska Department of Health and Social Services. A comprehensive statewide program cannot work smoothly and effectively without sufficient investment in program planning and coordination. Likewise, surveillance and evaluation provide critical feedback and help ensure accountability.

For example...

The Department of Health and Social Service's leadership role includes the following:

- In consultation with other public health groups (such as those represented by the Alaska Tobacco Control Alliance), the Department will develop and implement a comprehensive and effective statewide tobacco prevention and cessation program, which includes grants to external partners.
- Tobacco control program staff within the Department will closely monitor grants and provide technical assistance to grantees.
- Program staff will represent the state in meetings with other organizations and government entities, within Alaska and nationally, to learn and share information on effective program planning and implementation. Program staff may serve as media spokespersons on tobacco issues.
- The Department will have primary responsibility for ongoing data collection (surveillance) and evaluation to assess program effectiveness.

Costs and funding

A minimum budget of $650,000 is recommended for Statewide Coordination and Evaluation.

- $350,000 is budgeted for personnel costs, including office expenses and travel. Staff would likely include a Tobacco Control Program director, two staff to handle grants management and technical assistance, and a researcher.
- $300,000 is budgeted to support implementation and analysis of three critical statewide surveys: the Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Survey, and the Pregnancy Risk Assessment Monitoring System.

"Smaller states, or states with less money, should concentrate first on establishing a state level administrative office for the program that is adequate for leading, planning, evaluating, and monitoring the local program and media components."

from "A Model for Change: The California Experience in Tobacco Control"

CONCLUSION

Every week in Alaska, the equivalent of two to three classrooms of kids join the ranks of new smokers. Soon they become statistics for increased respiratory illnesses and increased doctor visits. Later they show up more frequently in hospitals. Some endure heart surgery, lung surgery, or years tethered to an oxygen tank because of the damage caused by tobacco. Eventually, a third of them will die prematurely from smoking-caused disease. Throughout those years and beyond, they and their loved ones suffer. Meanwhile, millions of dollars in precious resources are spent on tobacco-related medical care in our state.

Because 20 percent of all deaths in Alaska are caused by tobacco use, reducing nicotine addiction is one of the most important things we can do to enhance the quality of life for Alaskans.

We know what works. Because the people of California, Massachusetts, Arizona, and Oregon voted on statewide ballot initiatives to raise state tobacco taxes and dedicate a portion of the new revenues to comprehensive tobacco control programs, researchers and health advocates throughout the country have now seen that investing substantial resources in coordinated, comprehensive tobacco control programs will lead to substantial reductions in tobacco use.

Past experience with tobacco control efforts nationwide indicates that five principles should guide the development of a successful state program to prevent and reduce tobacco use:

- **It must be comprehensive.** Stopgap or partial measures will meet with only partial success.
- **It must be well-funded.** Unless properly financed, tobacco prevention will have little effect against the marketing efforts of the tobacco industry.
- **It must be sustained over a long period of time.** While short-term attitudinal changes can occur relatively early, it will take years to achieve the significant behavioral and cultural changes necessary to reduce tobacco use substantially and maintain low levels.
- **It must operate free and clear of political and tobacco industry influence.** History warns us that the tobacco industry will employ every manner of tactics to divert money from tobacco prevention and to interfere with any tobacco control efforts that are undertaken.
- **It must address high-risk and diverse populations.** The needs of special populations must be taken into account in designing and disseminating the various elements of the tobacco control program.

We know what works and we have the resources to fight this war and win. The time to act is now.

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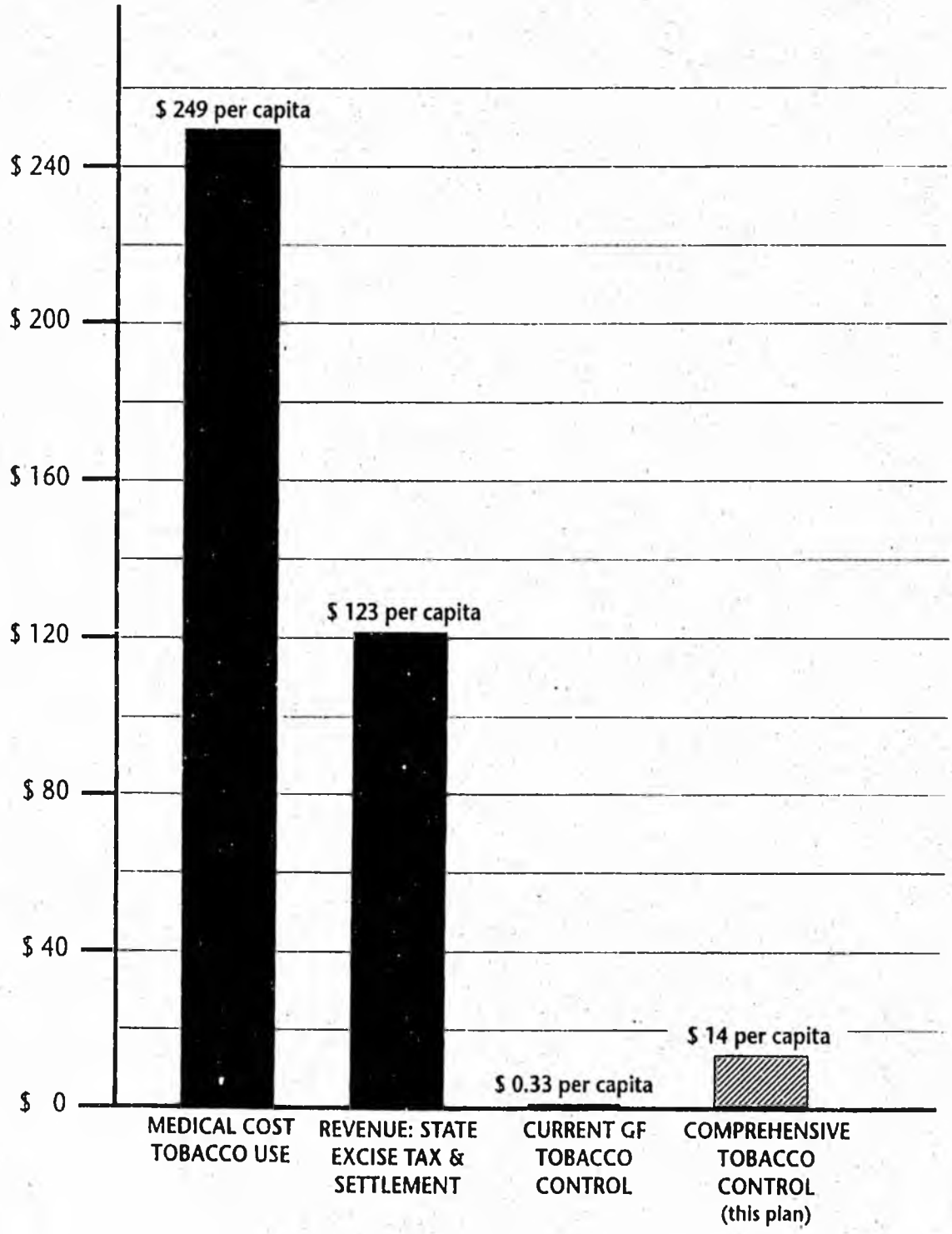
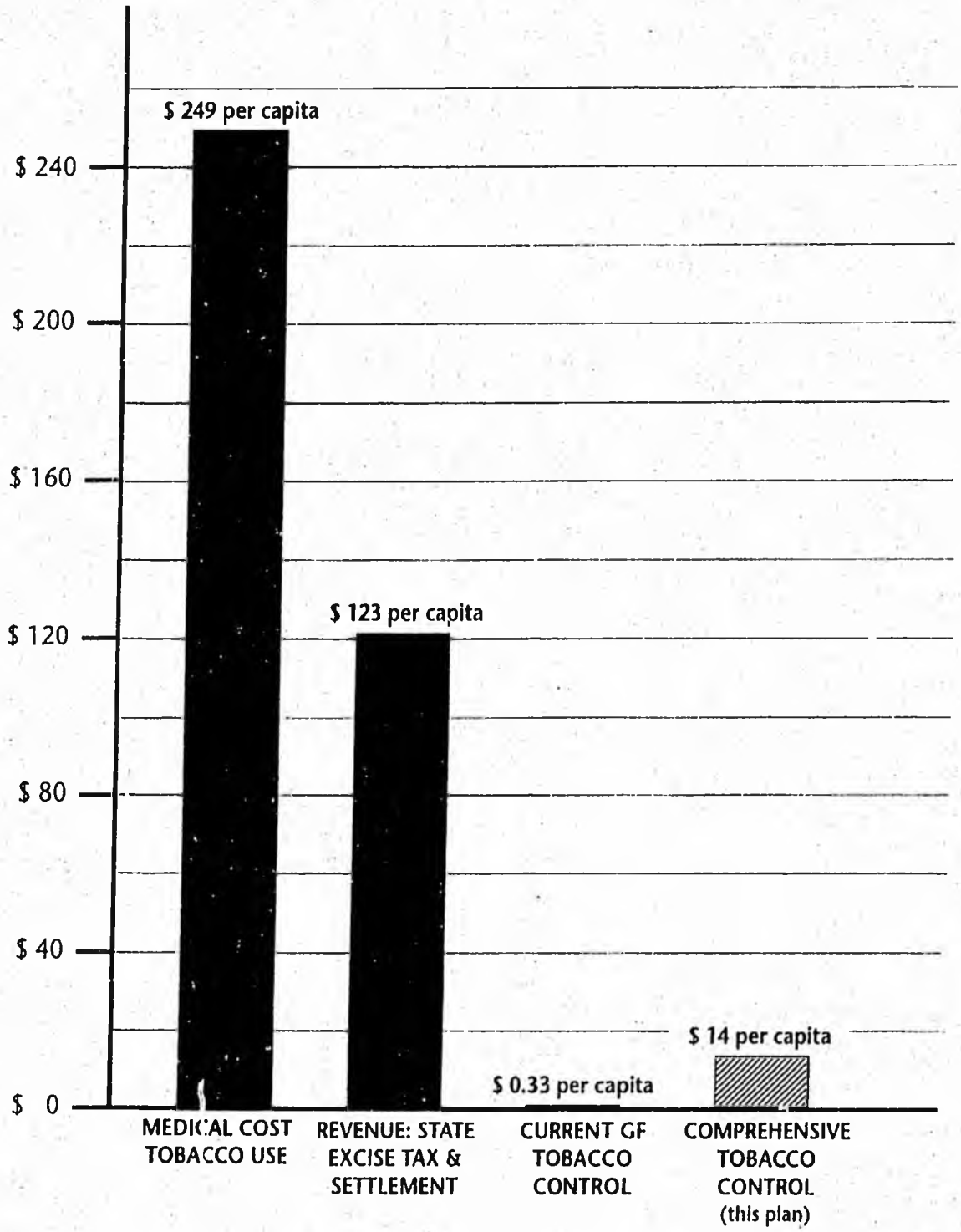
ALASKA: THE COST OF TOBACCO USE, STATE TOBACCO REVENUE, CURRENT GENERAL FUND SPENDING for TOBACCO CONTROL, and PROPOSED SPENDING, ATCA PLAN
(annual, per capita)



ALASKA: THE COST OF TOBACCO USE, STATE TOBACCO REVENUE, CURRENT GENERAL FUND SPENDING for TOBACCO CONTROL, and PROPOSED SPENDING, ATCA PLAN
(annual, per capita)



(11)

HOUSE COMMITTEE REPORT

Date Referred to Committee: April 9, 1999 FURTHER REFERRALS:

Date of Committee Action: 4/16/99

The FINANCE Committee considered: HB 37

HOUSE BILL NO. 37 SMOKING CESSATION AND EDUCATION PROGRAMS

"An Act relating to smoking education and cessation programs administered by the Department of Health and Social Services."

recommends it be replaced with the following committee substitute CS HB 37(FIN) [ ] the same title [ ] a new title

[ ] additional referral to _____ Committee
[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) _____ [ ] fiscal note(s) _____

[X] zero fiscal note(s) HFC for DHSS [X] zero fiscal note(s) DHSS, 3/19/99

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
Williams	X			
Austerman			X	
Brude			X	
Grussendorf			X	
Kohring				X
Mulder		X		
Therriault			X	
DAVIS			X	

CHAIR'S SIGNATURE _____

C-O

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. CSHB 37 (FIN)

Revision Date:
Title: Relating to Smoking Education and Cessation
Sponsor: Rokeberg
Requester:

Dept. Affected DHSS
BRU State Health Services
Component Tobacco Prevention and Control
Component Serial No. 2375

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 00	FY 01	FY 02	FY 03	FY 04	FY 05
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES [ ]						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1091 Designated Program Receipts						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY98) cost:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

Prepared by

Rep. Eldon Mulder, Co-Chair House Finance Committee Phone 465-2647

Rep. Gene Therriault, Co-Chair House Finance Committee Phone 465-4797

Date 4/16/99

No: 1

FISCAL NOTE

Bill Version: CSHB 37(HES)
(H) Publish Date: 3/19/99

STATE OF ALASKA
1999 LEGISLATIVE SESSION

Revision Date/Time (Note if correction) _____ Dept. Affected DHSS
Title _____ BRU Health Services
Relating to smoking education and cessation Component Community Health and EMS
Sponsor Rep Rokeberg _____
Requester House (HES) Component Serial No. 2078

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0
Contractual	0.0	0.0	0.0	0.0	0.0	0.0
Supplies	0.0	0.0	0.0	0.0	0.0	0.0
Equipment	0.0	0.0	0.0	0.0	0.0	0.0
Land & Structures	0.0	0.0	0.0	0.0	0.0	0.0
Grants & Claims	0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	0.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health	0.0	0.0	0.0	0.0	0.0	0.0
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY99) cost: 0.0

POSITIONS

Full-time	0	0	0	0	0	0
Part-time	0	0	0	0	0	0
Temporary	0	0	0	0	0	0

ANALYSIS: *(Attach a separate page if necessary)*
See attached documentation for the allocation of the tobacco settlement dollars included in the Governor's buget for these activities.

Prepared by Peter M Nakamura MD, MPH Phone 465-3090
Division Public Health Date/Time #########
Approved by Commissioner Date 3/9/99
Agency Department Of Health and social Services

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EFFECTIVE TOBACCO PREVENTION PROGRAMS

They Work

ESSENTIAL ELEMENTS

- Public Education (Counter-Marketing)
- Community-Based Programs
- School-Based Programs
- Helping Smokers Quit
- Enforcement
- Evaluation

GUIDING PRINCIPLES

- Comprehensive
- Well-funded
- Sustained over time
- Free of tobacco industry influence
- Address high risk and diverse populations

PUBLIC EDUCATION

Need

- Tobacco industry spends over $5 billion per year marketing its products
- Few effective counters to industry messages
- Kids especially vulnerable to tobacco advertising
- 86% of kids smoke the three most heavily advertised brands

PUBLIC EDUCATION Elements

- Include multiple media (tv, radio, print), as well as public relations, special events, etc.
- Complement school and community-based programs
- Target both youth and adults
- Include prevention and cessation messages
- No restrictions on content

PUBLIC EDUCATION
Effectiveness

- California anti-tobacco media campaign reduced sales of cigarettes by 232 million packs between the third quarter of 1990 and the fourth quarter of 1992.

- Vermont campaign reduced adolescent smoking by 35 percent beyond school program

COMMUNITY PROGRAMS
Need

- Necessary to reinforce messages from public education campaign
- Community involvement essential for meaningful change
- Reach people where they live, work, play, and worship
- Contribute to inclusiveness by involving diverse groups

COMMUNITY PROGRAMS
Elements

- Grants to community organizations, local government entities, local businesses, and other community partners
- Prevention and cessation; worksite programs; training for health professionals; enforcement, etc.
- Strict criteria for eligibility, accountability, and conflict of interest

COMMUNITY PROGRAMS
Effectiveness

- ASSIST Program reduced tobacco consumption by 7 percent within three years of inception

- Minnesota Heart Health Program reduced smoking by nearly 40 percent by Grade 12, compared to students in a school-based only program

SCHOOL-BASED PROGRAMS Need

- Most smokers start as kids
- Many misperceptions about tobacco use and its effects
- Kids require refusal skills and media literacy skills to resist peer and tobacco company influences
- Few schools implement evidence-based tobacco curriculum

SCHOOL-BASED PROGRAMS
Elements

- Develop and ENFORCE school tobacco policy
- Implement evidence-based curricula according to CDC guidelines in grades K-12; booster sessions critical
- Address consequences, social influences and peer norms, refusal skills, and media literacy

SCHOOL-BASED PROGRAMS
Elements (Cont)

- Provide training for teachers
- Provide assistance for teachers, students and staff who want to quit
- Involve parents and community

SCHOOL-BASED PROGRAMS
Effectiveness

- Best school programs have been demonstrated to reduce smoking prevalence by 20% by the end of Grade 12

- Recent study showed that a middle school social influences program reduced teen smoking even in a tobacco-producing region

HELPING SMOKERS QUIT
Need

- Most smokers want to quit, but few are able
- Many health professionals don't provide counseling
- New cessation products are promising but not accessible to all
- Adults are important role models for kids
- Second-hand smoke harms children
- Disease and cost reductions will come most quickly from smokers who quit

HELPING SMOKERS QUIT
Elements

- Training and support for health providers
- Quit lines for smokers who want help
- Combine physician counseling, skills training, and pharmacologic treatment
- Follow AHCPR guidelines
- Encourage and reinforce smokers who want to quit through other program elements

HELPING SMOKERS QUIT

Effectiveness

Long-Term Quit Rates

	No Advice	Brief Advice	Longer Counsel
No Meds	3%	11%	19%
Meds	10%	18%	30%

ENFORCEMENT
Need

- Kids have an easy time buying tobacco
- Minors illegally purchase over 250 million packs per year
- A majority (62%) of young smokers buy their own cigarettes
- Kids are successful buying tobacco a majority of the time
- Access laws often poorly enforced

ENFORCEMENT
Elements

- Responsibility and funding for enforcement with single agency
- Licensing of tobacco retailers
- Frequent compliance checks, with goal of 95% compliance
- Meaningful fines and, ultimately, license suspension for repeat offenders
- Education for merchants and the public

ENFORCEMENT
Effectiveness

- Enforcement in California and Massachusetts has dramatically reduced illegal sales to minors in those states
- Several community studies have shown that active enforcement of youth access laws increase merchant compliance
- A recent study in Minnesota showed that increased enforcement also reduced youth smoking

EVALUATION

- Crucial for accountability and continuous program improvement
- Baseline measures critical
- Process measures to monitor fidelity of implementation
- Regular monitoring of key outcome measures for each program element
- Set reasonable expectations

PROGRAM SUCCESS
Overall Consumption

- Since 1989, tobacco consumption in California has declined by 38% -- over twice the rate as the rest of the country (16%)

- Since 1992, tobacco consumption in Massachusetts has declined by 31 percent, or 4 times the 7% decrease in the rest of the country (excluding CA)

PROGRAM SUCCESS
Overall Consumption (Cont)

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

PROGRAM SUCCESS
Youth Smoking

- Less than a year after the initiation of Florida's Tobacco Pilot program, current smoking was reduced by 18% (3.4 percentage points) among middle school students and 8% (2.2 percentage points) among high school students.

- California and Massachusetts have avoided the dramatic increases in youth smoking that have occurred in the rest of the country.

PROGRAM SUCCESS
Youth Smoking (Cont)

- Since 1993, smoking among California 8th graders has varied from 12 to 14 percent while increasing from 17 to 22 percent in the rest of the country

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

PROGRAM SUCCESS
Youth Smoking (Cont)

- Between 1993 and 1996, smoking among 8th graders DECREASED slightly in Massachusetts while increasing dramatically elsewhere. Among 10th and 12 graders, smoking increased less in Massachusetts than elsewhere

- Between 1995 and 1997, smoking among high school students in Massachusetts decreased from 35.7% to 34.4 percent while increasing nationally from 34.4% to 36.4%.

PROGRAM SUCCESS
Youth Smoking (Cont)

- From 1993 to 1996, use of spit tobacco among 7th to 12th grade males in Massachusetts decreased from 15.3 to 8.3%

PROGRAM SUCCESS
Youth Smoking (Cont)

- Other early results from the Florida Tobacco Pilot Program are very encouraging:

  -- More than 90 percent of teens in Florida are aware of the campaign

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

  -- Likewise, the proportion who "strongly agree" that the tobacco companies try to get young people to smoke increased from 29 to 42 percent

PROGRAM SUCCESS
Youth Smoking (Cont)

- A 15-year follow-up study in Finland showed that the reductions in tobacco use produced by a mass media intervention combined with a school and community-based education program last over time. Mean lifetime cigarette consumption was 22 percent lower among program subjects than among control subjects.

PROGRAM SUCCESS
Youth Access

- The proportion of California tobaco retailers who failed compliance checks for selling tobacco products to minors declined from 52% in 1994 to 22% in 1997.

- The proportion of tobacco retailers in Massachusetts who sold tobacco illegally to minors has fallen from 48% to only 8% since the inception of the program.

PROGRAM SUCCESS
Adult Smoking

- From 1988 to 1996, adult smoking in California declined from 26.7% to 18.1%
- In Massachusetts, adult smoking prevalence has declined from 22.6% to 20.6% since the program began
- Preliminary data suggests that the prevalence of adult smoking in Oregon has already declined by 6.4%

PROGRAM SUCCESS
Pregnant Women

- In Massachusetts, smoking during pregnancy declined by 48% from 1990 to 1996 (From 25% to 13%)

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS:

LABOR &COMMERCE COMMITTEE, CHAIRMAN
JUDICIARY COMMITTEE, MEMBER
LEGISLATIVE COUNCIL, MEMBER
SPECIAL COMMITTEE ON UTILITY RESTRUCTURING, MEMBER
SPECIAL COMMITTEE ON ECONOMIC DEVELOPMENT & TOURISM, MEMBER

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Representative Norman Rokeberg

SECTIONAL ANALYSIS

CSHB37

"An Act relating to restricting sale of cigarettes, to enforcement of certain laws relating to sales of cigarettes, and to smoking education and cessation programs administered by the Department of Health and Social Services."

Prepared by: Representative Rokeberg

Section 1: Amends AS 43.70.075 (License endorsement) by adding new subsections which specify that:

- cigarettes be sold in groups of at least 20 and in the manufacturer's original cigarette pack or in a cigarette carton or box;
- cigarettes may not be sold or possessed if: (A) the cigarette package is not properly labeled according the federal Cigarette Labeling and Advertising Act; (B) the cigarette package indicates that the product was meant for export; (C) the cigarette package has been altered in order to conceal the language mentioned in (B).
- The commissioner of commerce and economic development may seize cigarettes not in compliance with this section and destroy them after notice and an opportunity for a hearing has been given.

Section 2: Amends AS 44.29.020(a) (Duties of department) to include a comprehensive smoking education, tobacco use prevention and tobacco control program in the list of state programs administered by the Department of Health and Social Services. Mandates that the program will include certain components, and will be conducted by contract or grant with more than one organization in the state.

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. CSHB37

Revision Date/Time (Note if correction) _____
Dept. Affected DHSS
Title Relating to Smoking Education and Cessation
BRU State Health Services
Component Tobacco Prevention & Control
Sponsor Rokeberg
Requester House (HES)
Component Serial No. 2375

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Personal Services	84.4	84.4	84.4	84.4	84.4	84.4
Travel	15.0	15.0	15.0	15.0	15.0	15.0
Contractual	1,026.0	1,026.0	1,026.0	1,026.0	1,026.0	1,026.0
Supplies	5.5	5.5	5.5	5.5	5.5	5.5
Equipment	7.5	7.5	7.5	7.5	7.5	7.5
Land & Structures						
Grants & Claims	1,860.0	1,860.0	1,860.0	1,860.0	1,860.0	1,860.0
Miscellaneous	1.6	1.6	1.6	1.6	1.6	1.6
TOTAL OPERATING	3,000.0	3,000.0	3,000.0	3,000.0	3,000.0	3,000.0
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	3,000.0	3,000.0	3,000.0	3,000.0	3,000.0	3,000.0
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	3,000.0	3,000.0	3,000.0	3,000.0	3,000.0	3,000.0

Estimate of any current year (FY99) cost: 0.0

POSITIONS

Full-time	1	1	1	1	1	1
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

A comprehensive tobacco prevention and control program is required if Alaska is ever to become tobacco-free. Based on CDC's "Best Practices" Guidelines, the attached one page summary describes the core components and requested funding levels of a comprehensive tobacco prevention and control program. A critical component of the program is the capacity for planning, evaluation, and surveillance. Funding is requested to support 0.5 FTE of a public health specialist and 0.5 FTE of a research analyst III. These positions would work with tobacco prevention and control staff to design and implement on-going surveillance and evaluation efforts required to monitor tobacco control efforts and use over time and to evaluate tobacco control efforts at all levels. Liasion work between the state and local programs, as well as training, are imperative. (See attached document for budget details)

Prepared by Peter M. Nakamura, MD
Phone 465-3090
Division Public Health
Date/Time 4/15/99 10:28 AM
Approved by Commissioner
Date 4/15/99
Agency Department Health and Social Services

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Local Community Programs and Statewide Partnerships ($1,439,475)

- Involve individuals in their homes, work sites, places of worship, entertainment venues, and civic organizations.
- Include community professional, geographic and ethnic diversity and strengths.
- Promote community-wide policies such as access and advertising restrictions, and clean indoor air initiatives.
- Promote and support accessible cessation programs.
- Statewide quit line providing general information, referrals, and self-help kits
- Physician training, and statewide evaluation coordination
- Re ing special populations such as outh, women, ethnic minorities, and low inco individuals
- Tech l support to provide up lates and materials on educational strategies, policy and current research
- Program coordination to expand diversity of alliance members to include tobacco industry target populations such as minorities, youth and women.

School-Based Programs - ($416,475)

- Promote a zero tolerance school poli y on tobacco use for students, staff, and visitors.
- Provide peer-teaching programs.
- Assure tobacco prevention instruction for all students and teachers.
- Provide cessation support for smokers.

Counter-Marketing - ($511,475)

- Place effective ads on primetime television, radio, billboard, and print.
- Focus on the responsibility of the industry both towards financial costs and health liability.
- Maintain tested, up to date, rapid response, and sustained ads.
- Provide technical assistance to local programs to ensure that statewide campaigns are coordinated with local efforts

Surveillance and Evaluation - ($257,100)

- Assist in local program evaluation and outcomes measurement work
- Develop capacity for data collection and analysis in such areas as regional, state, and national health and smoking cessation statistics.
- Produce reports and disseminate findings to partners, grantees, and policy makers.
- Provide training and technical assistance to partners and grantees on the collection and use of data in program evaluation.

Enforcement - ($375,475)

- FDA Merchant Inspections
- Local Agency Merchant Inspections/Prosecutions/Hearings
- Merchant Education
- Diversion Programs for under age offenders

No: 1

FISCAL NOTE

Bill Version: CS 3 37(HES)
(H) Publish Date: 3/19/99

STATE OF ALASKA
1999 LEGISLATIVE SESSION

Revision Date/Time (Note if correction) _____ Dept. Affected DHSS
Title _____ BRU Health Services
Relating to smoking education and cessation Component Community Health and EMS
Sponsor Rep Rokeberg
Requester House (HES) Component Serial No. 2078

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0
Contractual	0.0	0.0	0.0	0.0	0.0	0.0
Supplies	0.0	0.0	0.0	0.0	0.0	0.0
Equipment	0.0	0.0	0.0	0.0	0.0	0.0
Land & Structures	0.0	0.0	0.0	0.0	0.0	0.0
Grants & Claims	0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	0.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health	0.0	0.0	0.0	0.0	0.0	0.0
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY99) cost: 0.0

POSITIONS						
Full-time	0	0	0	0	0	0
Part-time	0	0	0	0	0	0
Temporary	0	0	0	0	0	0

ANALYSIS: *(Attach a separate page if necessary)*
See attached documentation for the allocation of the tobacco settlement dollars included in the Governor's buget for these activities.

Prepared by Peter M Nakamura MD, MPH Phone 465-3090
Division Public Health Date/Time #########
Approved by Commissioner Date 3/9/99
Agency Department Of Health and social Services

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EXHIBIT B

Annual Payments to Each State

Year	1998	1999	2000	2001	2002	2003	2004 to 2007	2008 to 2017	2018 to 2025	Total
Amount	$2,400,000,000.00	$0.00	$6,411,750,000.00	$6,923,660,000.00	$8,313,294,800.00	$8,391,971,144.00	$7,004,000,000.00	$7,143,000,000.00	$8,003,999,997.00	$195,918,675,920.00
Alabama	$38,787,139.87	$0.00	$103,622,268.35	$111,895,403.67	$134,353,720.06	$135,625,232.71	$113,193,803.17	$115,440,225.02	$129,355,111.40	$3,166,302,118.81
Alaska	$8,194,049.54	$0.00	$21,890,915.46	$23,638,672.09	$28,383,145.58	$28,651,761.36	$23,912,967.90	$24,387,539.93	$27,327,155.19	$668,903,056.50
Arizona	$35,373,226.92	$0.00	$94,501,786.55	$102,046,748.46	$122,528,359.76	$123,687,958.17	$103,230,867.24	$105,279,566.63	$117,969,711.74	$2,887,614,909.02
Arkansas	$19,873,586.24	$0.00	$53,093,527.74	$57,332,480.87	$68,839,575.47	$69,491,067.60	$57,997,749.17	$59,118,761.04	$66,278,410.08	$1,622,336,125.69
California	$306,334,930.78	$0.00	$818,392,913.50	$883,732,877.84	$1,061,105,244.62	$1,071,147,458.11	$893,987,439.65	$911,729,337.72	$1,021,626,993.76	$25,006,972,510.74
Colorado	$32,900,674.16	$0.00	$87,896,207.30	$94,913,784.01	$113,963,751.40	$115,042,295.05	$96,015,134.08	$97,920,631.45	$109,723,748.27	$2,685,773,548.89
Connecticut	$44,556,896.25	$0.00	$119,036,533.13	$128,540,333.44	$154,339,422.45	$155,800,078.15	$130,031,875.55	$132,612,462.45	$148,597,248.93	$3,637,303,381.55
Delaware	$9,491,268.84	$0.00	$25,356,517.92	$27,380,966.02	$32,876,548.30	$33,187,689.27	$27,698,686.24	$28,248,388.89	$31,653,381.58	$774,798,676.89
D.C.	$14,570,838.84	$0.00	$38,926,906.65	$42,034,805.86	$50,471,532.83	$50,949,191.30	$42,522,564.69	$43,366,459.11	$48,593,747.53	$1,189,458,105.56
Florida	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Georgia	$58,906,980.41	$0.00	$157,373,679.86	$169,938,293.33	$204,046,289.14	$205,977,386.58	$171,910,204.50	$175,321,900.45	$196,454,779.60	$4,808,740,668.60
Hawaii	$14,444,759.81	$0.00	$38,590,078.62	$41,671,085.70	$50,034,811.08	$50,508,336.45	$42,154,624.04	$42,991,216.38	$48,173,273.94	$1,179,165,923.07
Idaho	$8,718,317.14	$0.00	$23,291,529.13	$25,151,109.85	$30,199,141.89	$30,484,944.11	$25,442,955.52	$25,947,891.39	$29,075,587.65	$711,700,479.23
Illinois	$111,701,933.67	$0.00	$298,418,697.16	$322,244,254.19	$386,921,293.46	$390,583,085.03	$325,983,476.42	$332,452,880.08	$372,525,948.64	$9,118,539,559.10
Indiana	$48,955,278.39	$0.00	$130,787,085.94	$141,229,042.84	$169,574,858.88	$171,179,701.52	$142,867,820.78	$145,703,147.32	$163,265,853.39	$3,996,355,551.01
Iowa	$20,872,006.95	$0.00	$55,760,871.07	$60,212,783.18	$72,297,977.85	$72,982,200.02	$60,911,473.61	$62,120,310.68	$69,608,143.15	$1,703,839,985.56
Kansas	$20,008,109.65	$0.00	$53,452,915.44	$57,720,561.87	$69,305,547.47	$69,961,449.52	$58,390,333.34	$59,549,136.35	$66,727,045.67	$1,633,317,646.19
Kentucky	$42,267,806.11	$0.00	$112,921,085.75	$121,936,632.68	$146,410,305.30	$147,795,920.49	$123,351,547.49	$125,799,557.93	$140,963,133.32	$3,450,438,586.10
Louisiana	$54,128,474.21	$0.00	$144,607,601.88	$156,152,979.89	$187,494,151.32	$189,268,580.68	$157,964,930.57	$161,099,871.36	$180,518,461.42	$4,418,657,915.22
Maine	$18,464,411.55	$0.00	$49,328,829.47	$53,267,211.52	$63,958,373.54	$64,563,670.37	$53,885,307.70	$54,954,704.87	$61,578,810.49	$1,507,301,275.81
Maryland	$54,250,967.50	$0.00	$144,934,850.37	$156,506,355.69	$187,918,452.52	$189,696,897.43	$158,322,406.83	$161,464,442.03	$180,926,976.56	$4,428,657,383.58
Mass.	$96,935,496.43	$0.00	$258,969,237.19	$279,645,174.68	$335,772,232.68	$338,949,953.70	$282,890,090.42	$288,504,271.26	$323,279,880.48	$7,913,114,212.77
Michigan	$104,446,741.41	$0.00	$279,035,997.59	$301,318,052.34	$361,790,230.09	$365,214,183.32	$304,810,407.01	$310,859,614.11	$348,329,882.46	$8,526,278,033.60
Minnesota	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Mississippi	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Missouri	$54,590,725.53	$0.00	$145,841,733.70	$157,485,644.00	$189,094,291.94	$190,883,864.90	$159,313,058.50	$162,474,753.97	$182,059,069.06	$4,456,368,286.30
Montana	$10,194,218.72	$0.00	$27,234,492.45	$29,408,876.82	$35,311,477.28	$35,645,662.22	$29,750,128.30	$30,340,543.46	$33,997,719.42	$832,182,430.63
Nebraska	$14,279,599.86	$0.00	$38,148,843.51	$41,194,622.66	$49,462,718.04	$49,930,829.17	$41,672,632.27	$42,499,659.09	$47,622,465.53	$1,165,683,457.48
Nevada	$14,638,443.42	$0.00	$39,107,516.49	$42,229,835.47	$50,705,706.47	$51,185,581.14	$42,719,857.37	$43,567,667.21	$48,819,208.77	$1,194,976,854.76
New Hampshire	$15,982,416.92	$0.00	$42,698,025.70	$46,107,008.63	$55,361,059.77	$55,884,992.33	$46,642,020.04	$47,567,668.35	$53,301,360.40	$1,304,689,150.27
New Jersey	$92,807,910.83	$0.00	$247,942,134.27	$267,737,674.95	$321,474,801.04	$324,517,212.33	$270,844,419.77	$276,219,544.60	$309,514,382.50	$7,576,167,918.47
New Mexico	$14,313,352.87	$0.00	$38,239,016.77	$41,291,995.30	$49,579,634.15	$50,048,851.76	$41,771,134.78	$42,600,116.47	$47,735,031.79	$1,168,438,809.05
New York	$306,288,745.07	$0.00	$818,269,525.50	$883,599,638.62	$1,060,945,263.21	$1,070,985,962.65	$893,852,654.37	$911,591,877.52	$1,021,472,964.43	$25,003,202,243.12
North Carolina	$55,974,840.09	$0.00	$149,540,283.73	$161,479,483.90	$193,889,727.95	$195,724,684.52	$163,353,241.67	$166,595,117.83	$186,676,091.64	$4,569,381,898.24
North Dakota	$8,784,330.94	$0.00	$23,467,889.12	$25,341,550.30	$30,427,805.29	$30,715,771.56	$25,635,605.78	$26,144,364.95	$29,295,743.66	$717,099,369.09
Ohio	$120,900,234.58	$0.00	$322,992,532.93	$348,780,049.22	$418,783,038.09	$422,746,166.61	$352,827,184.57	$359,829,323.15	$403,202,282.16	$9,869,422,448.51
Oklahoma	$24,867,287.65	$0.00	$66,434,513.15	$71,738,602.00	$86,137,122.12	$86,952,316.82	$72,571,034.45	$74,011,264.86	$82,932,404.27	$2,029,985,862.29
Oregon	$27,543,797.82	$0.00	$73,584,977.37	$79,459,954.68	$95,408,213.01	$96,311,148.56	$80,381,983.32	$81,977,228.27	$91,858,565.71	$2,248,476,833.11
Penn.	$137,924,610.41	$0.00	$368,474,217.00	$397,892,961.71	$477,753,311.05	$482,274,729.42	$402,509,988.05	$410,498,121.73	$459,978,575.54	$11,259,169,603.46
Rhode Island	$17,253,727.23	$0.00	$46,094,410.65	$49,774,558.78	$59,764,717.02	$60,330,325.43	$50,352,127.30	$51,351,405.67	$57,541,180.29	$1,408,469,747.28
South Carolina	$28,232,446.75	$0.00	$75,424,744.69	$81,446,607.84	$97,793,603.59	$98,719,114.28	$82,391,688.98	$84,026,818.16	$94,155,208.21	$2,304,693,119.82
South Dakota	$8,374,699.41	$0.00	$22,373,532.90	$24,159,821.39	$29,008,893.79	$29,283,431.59	$24,440,164.46	$24,925,199.13	$27,929,622.54	$683,650,008.54
Tennessee	$58,581,467.29	$0.00	$156,504,051.21	$168,999,234.09	$202,918,753.08	$204,839,159.61	$170,960,248.71	$174,353,092.02	$195,369,193.34	$4,782,168,127.09
Texas	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Utah	$10,677,285.47	$0.00	$28,525,035.47	$30,802,455.97	$36,984,759.08	$37,334,779.83	$31,159,878.10	$31,778,270.89	$35,608,747.04	$871,616,513.42
Vermont	$9,868,441.49	$0.00	$26,364,158.22	$28,469,055.67	$34,183,026.39	$34,506,531.76	$28,799,401.75	$29,370,948.99	$32,911,252.36	$805,588,329.25
Virginia	$49,073,882.70	$0.00	$131,103,944.75	$141,571,199.45	$169,985,689.11	$171,594,419.81	$143,213,947.68	$146,056,143.38	$163,661,398.74	$4,006,037,550.26

Washington$49,278,196.65	$0.00	$131,649,782.25	$142,160,616.27	$170,693,406.67	$172,308,835.15	$143,810,203.90	$146,664,232.79	$164,342,785.78	$4,022,716,266.79
West Virginia $21,275,048.98	$0.00	$56,837,623.03	$61,375,502.33	$73,694,064.18	$74,391,498.79	$62,087,684.60	$63,319,864.52	$70,952,288.31	$1,736,741,427.33
Wisconsin $49,728,936.59	$0.00	$132,853,962.15	$143,460,937.12	$172,254,712.48	$173,884,917.03	$145,125,613.28	$148,005,747.52	$165,846,003.46	$4,059,511,421.32
Wyoming $5,960,276.82	$0.00	$15,923,252.04	$17,194,554.25	$20,645,640.96	$20,841,029.62	$17,394,074.52	$17,739,273.88	$19,877,523.19	$486,553,976.10
Amercian Samo a$365,208.62	$0.00	$975,677.65	$1,053,575.12	$1,265,036.21	$1,277,008.41	$1,065,800.48	$1,086,952.15	$1,217,970.74	$29,812,995.31
N. Marianas $202,503.22	$0.00	$541,000.00	$584,193.09	$701,445.39	$708,083.81	$590,971.89	$602,700.20	$675,348.22	$16,530,900.80
Guam $526,489.51	$0.00	$1,406,549.63	$1,518,847.65	$1,823,692.71	$1,840,951.99	$1,536,471.89	$1,566,964.41	$1,755,842.52	$42,978,803.27
US Virgin Island $416,623.09	$0.00	$1,113,034.64	$1,201,898.61	$1,443,129.42	$1,456,787.08	$1,215,845.06	$1,239,974.49	$1,389,438.02	$34,010,102.11
Puerto Rico $26,910,657.33	$0.00	$71,893,502.96	$77,633,434.04	$93,215,094.84	$94,097,274.89	$78,534,268.30	$80,092,843.87	$89,747,042.15	$2,196,791,813.07
$2,400,000,000.00	$0.00	$6,411,750,000.00	$6,923,660,000.00	$8,313,294,800.00	$8,391,971,144.00	$7,004,000,000.00	$7,143,000,000.00	$8,003,999,997.00	$195,918,675,920.00

Source: National Association of Attorneys General (http://www.naag.org/tob2.htm)

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS:

LABOR &COMMERCE COMMITTEE, CHAIRMAN
JUDICIARY COMMITTEE, MEMBER
LEGISLATIVE COUNCIL, MEMBER
SPECIAL COMMITTEE ON UTILITY RESTRUCTURING, MEMBER
SPECIAL COMMITTEE ON ECONOMIC DEVELOPMENT & TOURISM, MEMBER

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Representative Norman Rokeberg

SPONSOR STATEMENT

CSHB37

"An Act relating to restricting sale of cigarettes and to smoking education and cessation programs administered by the Department of Health and Social Services"

This legislation was introduced in conjunction with CSHB21, which allocates the $669 million that Alaska will receive under the tobacco settlement. CSHB37 adds a comprehensive smoking education, tobacco use prevention, and tobacco control program to the list of state programs administered by the Department of Health and Social Services. It also contains provisions to bolster tobacco control enforcement efforts in Alaska.

SMOKING IS THE LEADING CAUSE OF DEATH IN ALASKA. According to the Alaska Tobacco Control Alliance, about 500 Alaskans die every year from smoking-related illnesses. Alaska has one of the highest smoking rates in the country—110,000 smokers—and more than 80 percent of Alaskans who smoke report that they want to quit. We need to lend a hand to those who want to quit, and prevent people—our youth, in particular—from starting this potentially deadly habit.

CSHB37 outlines a comprehensive tobacco control program based on the Center for Disease Control's guidelines. Similar programs in California and Massachusetts have yielded remarkable results: cigarette consumption in California has declined 40% overall, and smoking in Massachusetts has decreased by 31%. Alaska is long overdue for such a program. The sooner we implement it, the sooner we can save lives and reduce the costs to individuals and the State for smoking-related illnesses.

Additionally, this bill prohibits sales of cigarettes in groups of less than 20, not in their original packaging, and not properly labeled for sale in the United States. By strengthening tobacco control enforcement, these provisions help support the comprehensive program.

It is the sponsor's intention that upon passage of this bill, contractual agreements will be made with organizations such as the American Lung Association of Alaska, the American Cancer Society, and the Alaska Native Health Board to implement the program. The Department of Health and Social Services will be responsible for oversight; we do not need to contribute to government bureaucracy by burdening the State with additional programmatic duties.

This bill will be a valuable tool in shaping the future of **all** Alaskans—whether they be young or old, smokers or not—by improving their overall health, decreasing smoking-related medical costs, protecting our future generations from the negative effects of smoking, and even saving lives.

I urge you to support this legislation.

The impact of —tobacco in Alaska—

Tobacco use is the leading cause of preventable death in Alaska. One out of five deaths in the state are attributable to smoking.

- Approximately 500 Alaskans die each year from smoking-related causes.
- Cigarettes kill more Americans each year than alcohol, AIDS, murders, suicides, car accidents, cocaine, heroin, and fires combined.
- Deaths related to cigarette smoking include a portion of cardiovascular disease; cancers of the lung, larynx, oral cavity, esophagus, pancreas, bladder, kidney, and cervix; chronic bronchitis, emphysema, and other respiratory deaths.
- Alaska's smoking rate among adults is 26.7% (1997). Among high school students, the rate is 36.5% (1995). State goals (Healthy Alaskans 2000) call for reducing the smoking prevalence among both youth and adults to no more than 15%.

Tobacco addiction starts with kids

- Tobacco addiction almost always starts in childhood or adolescence. The average age of smoking initiation is 14.5. Almost 90% of smokers start before the age of 19.
- The number of American teenagers taking up smoking as a daily habit jumped 73% between 1988 and 1996. Youth smoking and smokeless tobacco use rates in Alaska are higher than in the U.S. as a whole.
- Four thousand Alaskan kids join the ranks of daily cigarette smokers each year.

Smokers need help in quitting

- Researchers widely regard nicotine to be as addictive as heroin or cocaine.
- More than 80% of Alaskans who smoke report that they want to quit.
- Studies show that most smokers don't receive cessation advice from doctors and are confused about the best strategies for quitting.

Passive smoking/secondhand smoke

- Smoking can cause spontaneous abortion in pregnant women who smoke, as well as premature birth and low birth weight infants. Maternal smoking can cause Sudden Infant Death Syndrome.
- Secondhand smoke kills approximately 54,000 Americans each year, making it the third leading cause of death in the country. For every eight smokers killed by tobacco, one non-smoker dies too (60 each year in Alaska).

The economic burden of tobacco

- Total medical expenditures attributable to smoking amount to over $70 billion a year in the U.S. In Alaska, these expenditures total $154 million annually. Of this total, Medicaid pays about $23 million.
- Additional direct health care expenditures caused by tobacco include the costs related to exposure to secondhand smoke, smoking-caused fires, and smokeless tobacco use. These costs are believed to total in the tens of millions of dollars.
- Other non-health costs by tobacco include work productivity losses and direct residential and commercial property losses from fires caused by smoking.

(over)→

The Alaska Tobacco Control Program

Executive Summary

Components of the proposed comprehensive tobacco control program for Alaska are:

- *Community Programs – $2 million*
- *Cessation Programs – $1.4 million*
- *Counter-marketing – $1 million*
- *School-based Programs – $750,000*
- *Tobacco-Free Partnership Projects– $1.8 million*
- *Enforcement – $600,000*
- *Program Development, Management, and Evaluation– $650,000*

TOTAL: $8.2 million

BACKGROUND

Investing in tobacco prevention and cessation WORKS, saving lives and dollars. The clearest evidence of this comes from California and Massachusetts, two states that have invested significant resources (from tobacco tax revenues) to fund comprehensive tobacco control programs.

In California, which has the longest-running tobacco control program, **cigarette consumption has declined by more than 40%** since 1988. In Massachusetts, a 25¢ tax increase and large, comprehensive tobacco control program have reduced smoking consumption by 31% since 1994.

The federal Centers for Disease Control and Prevention has analyzed the experience in California, Massachusetts, and other states to identify **components of effective state tobacco control programs and recommend funding levels** to achieve tobacco use reduction goals in each state.

For Alaska, **CDC guidelines** specify a lower estimate of $8.7 million and an upper estimate of $17.7 million annually for comprehensive tobacco prevention and control. The **Alaska Tobacco Control Alliance** has studied the CDC guidelines as well as information from other sources and developed a tobacco control plan funded at $8.2 million annually (minimum level).

ATCA's plan for preventing tobacco-caused addiction, disease, and death in Alaska calls for a **broad-based collaborative effort** involving state and local policy makers, the professional health care community, businesses, educators, parents, and children. Major goals are to prevent children from becoming addicted to tobacco, help youth and adults who want to quit, and protect nonsmokers from secondhand smoke. The ATCA plan incorporates **proven strategies** for tobacco use reduction.

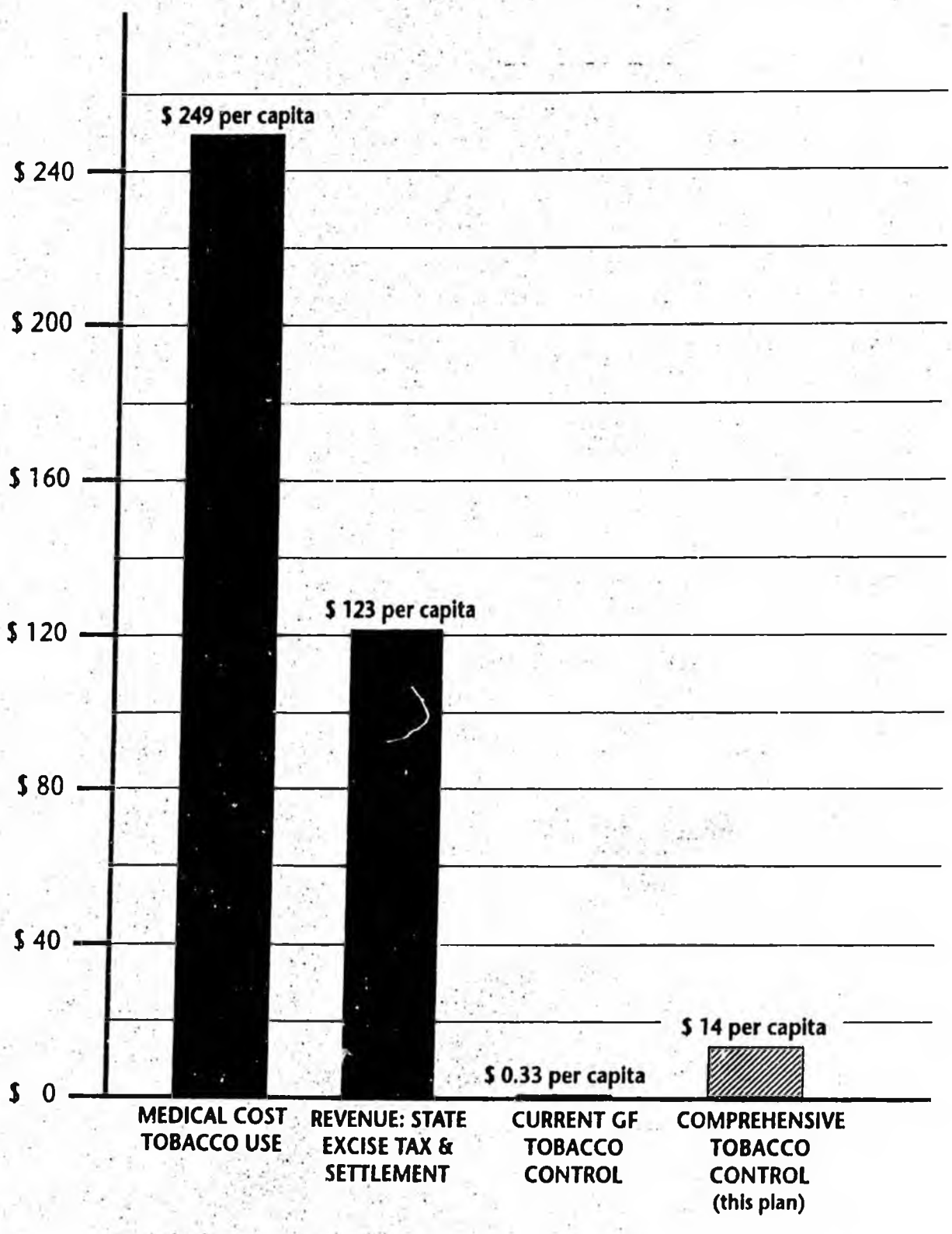
In November 1998, **Alaska joined a multi-state settlement with the tobacco industry** that is expected to provide $669 million over the next 25 years. The ATCA plan for tobacco control could be funded with less than a third of the average annual payment from the settlement.

Alaska's share of the multi-state settlement includes **an extra $200 million** that was negotiated to cover the costs associated with implementing a comprehensive tobacco control program.

Revenue from tobacco sources in Alaska (tobacco taxes and settlement payments) will soon exceed $70 million annually. However, the state currently spends only $200,000 from general fund revenues for tobacco control efforts.

In a **statewide survey of registered voters** conducted in October 1998, 77% of respondents said that at least half of the tobacco settlement money coming to Alaska should be used for programs to reduce tobacco use.

ALASKA: THE COST OF TOBACCO USE, STATE TOBACCO REVENUE, CURRENT GENERAL FUND SPENDING for TOBACCO CONTROL, and PROPOSED SPENDING, ATCA PLAN
(annual, per capita)



The Alaska Tobacco Control Program

Program Components

The seven essential components of a comprehensive tobacco control program are:

COMMUNITY PROGRAMS

Community efforts to change public attitudes and behaviors about tobacco represent a key component in any comprehensive program to reduce tobacco addiction. Such efforts must involve as many community members as possible in planning and carrying out public awareness campaigns and other activities to promote tobacco-free social norms. Coordination and technical assistance will ensure that community partners are accountable for effective project implementation.

CESSATION PROGRAMS

The vast majority of smokers want to quit. Those who succeed greatly reduce their risk of smoking-related disease and early death. In addition, helping adults to quit smoking protects their children from the dangers of secondhand smoke and can reduce the number of newborn babies who suffer or die as a result of "passive smoking." Cessation programs that include counseling and pharmaceutical support can increase success rates dramatically. Other components of a statewide tobacco control program, such as community-based projects and a high profile media campaign, will help motivate smokers to take advantage of cessation services.

TOBACCO-FREE PARTNERSHIP PROJECTS

Within this component, a variety of external partners will expand project reach and impact by targeting at-risk populations, incorporating tobacco prevention and cessation efforts within other health programs, and providing critical networking, communications, technical assistance, and research services from outside the state bureaucracy. Like the Quit Line and counteradvertising campaign, these projects are statewide in scope.

COUNTERMARKETING

No one knows better than the tobacco industry the power of advertising and product promotion. Health advocates can use these same tools with powerful impact. Research shows that tobacco countermarketing promotes quitting, decreases the likelihood of initiation, and supports school and community efforts to create tobacco-free social norms.

SCHOOL-BASED PROGRAMS

While almost all children know that "smoking is bad for you," this fact alone has not prevented a dramatic increase in youth smoking since 1988. The Centers for Disease Control and Prevention has evaluated school-based tobacco prevention programs and issued guidelines for choosing and implementing an effective program. When these guidelines are followed, a school-based program can reduce smoking prevalence significantly.

ENFORCEMENT

Enforcement of tobacco control policies enhances their efficacy both by deterring violations and by sending a message to the public that community leadership believes the policies are important. Existing laws and new laws in the areas of youth access, tax compliance, and clean indoor air all require enforcement for maximum impact.

PROGRAM DEVELOPMENT, MANAGEMENT, and EVALUATION

Ultimate accountability for the wise use of state tobacco control program dollars must rest with the Alaska Department of Health and Social Services. A comprehensive statewide program cannot work smoothly and effectively without sufficient investment in program planning and coordination. Likewise, surveillance and evaluation provide critical feedback and help ensure accountability.

For more information, contact Christie McIntire, Chair, Alaska Tobacco Control Alliance • 907-276-5864

ALASKA STATE LEGISLATURE
House of Representatives

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Representative Norman Rokeberg

Many organizations and individuals support the use of tobacco funds for the program outlined in House Bill 37. The following is a list of those who have sent messages and letters of support:

American Cancer Society
American Lung Association
Alaska Native Health Board
American Industrial Hygiene Association, Midnight Sun Section
Alaska Academy of Physician Assistants
Alaska Dental Society
Alaska State Dental Hygienists' Association
Rena Anderson, RDH
Alaska Association of Elementary School Principals
Alaska Women's Resource Center
Southeast Alaska Regional Health Consortium
Native Village of Gambell
Office of Health Nations
Recovery Center, Ketchikan General Hospital
"Haa Gaaw aat lax-ee" (The Drum Dancers)
Juneau Tobacco Prevention Network
Anchorage School Board
Cordova Public Schools
Teens Against Tobacco Use
Judy Downs, RN, Safe and Drug Free Schools
Jane Combs, PHN (for Barrow's public health nurses and self)
Dr. Hal Post, UAA, retired
Judith Bendersky, Public Health Educator
Christina Reagle
Evelyn Williams
Paul Barrett

My office has also received numerous POMs from individuals favoring the use of tobacco settlement funds for tobacco control and cessation programs.

ADN 2/4/99

Settlement could aid smokers

I am writing this letter concerning Alaska's tobacco settlement.

The state of Alaska says it's going to use the money for teenage smoking. I don't believe that. It's going in the pockets of the Anchorage Police Department and the politicians. My father died from emphysema, so it's too late to help him. Now my wife is trying to quit. She and many others started smoking as teenagers. What about them?

The taxes on cigarettes were paid by these people and should be used to give them the help they need to quit. Put this money where it belongs to help the people who paid it with their lungs and taxes over many years.

Make it harder for teens to get tobacco by selling it only in special smoke shops and alcohol establishments where IDs are already checked and you wouldn't have to pay APD officers overtime to stake out the places teens frequent. Some examples are movie theaters, service stations, restaurants, malls, grocery stores — the list is endless.

If the people and politicians are serious about stopping teenage smoking, take away all the chances they have to buy cigarettes each day.

If they even enter an alcohol establishment they can be fined $1,000. Make it the same for the smoke shops. If they can't get them, they can't smoke them. Then the people who really need the help, that the tobacco settlement represents, would be able to get the medical help they need to quit the deadly habit they acquired by the greed of the tobacco companies.

These people are the ones who are hooked and in danger, not the teens who could easily be stopped.

— Dan Gates
Chuglak

Source: Campaign for Tobacco-Free Kids

Why Alaska Should Use Its Tobacco Settlement Money To Support A New Comprehensive Statewide Tobacco Control Strategy

Alaska has already begun deciding how to use the millions of dollars it will receive each year from the settlement agreement with the tobacco companies. While some state legislators and others might be tempted to direct these new funds to a tax cut or to other favorite projects or causes, the arguments for directing a substantial portion of the settlement payments to establish a comprehensive statewide tobacco control strategy are overwhelming. It would substantially reduce smoking and other tobacco use, save thousands of lives and millions of dollars, dramatically improve public health, and do more to help Alaska and its citizens than any other option.

Tobacco Company Payments Should Go To Fight Tobacco Company Harms. The tobacco companies' payments to Alaska for past tobacco-related harm to the state should be used to reduce the amount of damage tobacco use will cause Alaska and its citizens in the future -- and that means using settlement funds to sharply curtail smoking and other tobacco use throughout the state, especially among children.

The Public Supports Using Tobacco Settlement Money For Tobacco Control. In a pre-election poll of likely Alaska voters, 77% said that about half or more of the settlement funds should be spent to reduce smoking among kids (with only 1% saying that none of the funds should be so used). Similarly, in a recent nationwide poll, 84 percent of the respondents favored spending the money their state receives to reduce tobacco use among kids, including more than two-thirds (69%) who "strongly favor" spending the money for this purpose.

The Smoking Problem Is Big And Getting Worse. Approximately 27 percent of adult men and 25 percent of adult women in Alaska are current smokers, along with 36 percent of all high school students. While adult smoking has generally been declining in recent years, the number of kids who are smoking has been increasing steadily throughout the 1990s, and has only just experienced a small decline. Underage smoking remains at historically high levels, and over the past 10 years the number of kids under 18 who become daily smokers each year has increased by more than 70 percent. In Alaska alone, more than 4,000 kids under 18 become new daily smokers each year.

A Comprehensive Statewide Tobacco Control Strategy Would Dramatically Reduce Smoking And Other Tobacco Use In Alaska. California and Massachusetts have already initiated tobacco control campaigns that have reduced overall smoking levels within their borders at a faster rate than elsewhere in the country. Similarly, while youth smoking rates were going up nationwide, in California and Massachusetts they either declined or increased much more slowly -- despite significant reductions to both states' tobacco control efforts and despite aggressive tobacco company efforts to dampen the impact of the state programs.

New Tobacco Control Spending Will Save Lives. Tobacco use is responsible for more deaths than alcohol, auto accidents, AIDS, suicides, murders, and illegal drugs combined. Each year, about 400 people die from smoking-related causes in Alaska, and countless others suffer from tobacco-related disease and distress, including many of those exposed to second hand smoke. If current smoking trends are not reversed, roughly 17,000 of the children currently alive in the state will eventually die from smoking-related causes. Directing tobacco settlement monies to tobacco control can reduce this unnecessary disease, misery, and death -- and there is no better investment Alaska can make to save lives and improve public health.

New Tobacco Control Spending Will Save Alaska Money. Public and private direct expenditures in Alaska to treat health problems caused by smoking annually total roughly $150 million, with the state government paying approximately $20 million every year in cigarette-related Medicaid expenditures. Alaska and its citizens annually pay millions more for health care relating to smokeless tobacco use, cigar and pipe smoking, and exposure to second hand smoke. Beyond these direct health expenditures are tobacco-related labor costs and lost productivity (e.g., tobacco-related sick days); damage and loss from cigarette-related fires; and tobacco-related maintenance and cleaning expenses. An aggressive statewide tobacco control strategy would reduce all of these tobacco-related costs and save the state, its businesses, and its citizens many millions of dollars each and every year.

Nickel And Diming The Problem Won't Work. Significantly reducing tobacco use in Alaska requires substantial investment in a sustained and comprehensive multi-year tobacco control strategy. Anything less will not effectively counter the addictive power of nicotine or the tobacco companies' advertising and marketing expenditures (more than $11 million per year in Alaska). Existing tobacco control efforts throughout the country show that the best way to reduce tobacco use, other than raising prices, is to take full advantage of a wide range of proven effective measures, including counter advertising, school and community-based prevention and cessation programs, the enhanced enforcement of laws prohibiting the sale of tobacco products to kids, and the firm maintenance of smoke-free workplaces and public areas. While any one of these tobacco control measures can reduce tobacco use by itself, they work much more powerfully and effectively when done together.

Relying On The Settlement Agreement's Tobacco Control Provisions Won't Work. Although the tobacco settlement contains some useful restrictions on tobacco marketing, they will not, by themselves, significantly hinder the tobacco industry's ability to market to kids. Similarly, the new national public education campaign financed by the multi-state settlement can significantly reduce tobacco use only if it is accompanied by strong state tobacco control efforts. Put simply, the tobacco settlement can dramatically cut tobacco use in Alaska only if the state uses its tobacco company payments to finance new tobacco control initiatives.

If The State Doesn't Do It, No One Else Will. Because of a special provision in the settlement agreement, until 2003 the tobacco companies' payments to Alaska will be reduced by any new federal funding made available to the state for tobacco control efforts that comes from an increase in the federal tobacco tax or from any other new charges against the tobacco companies. Consequently, it is highly unlikely that Congress will direct any new federal tobacco control funding to Alaska for some time.

Adequately Funding A Comprehensive Statewide Tobacco Control Strategy Would Still Leave Plenty Of Settlement Funding For Other Purposes. The U.S. Centers for Disease Control and Prevention estimates that adequately funding a comprehensive tobacco control effort in Alaska requires $8 to $17 million per year in new funding. Accordingly, Alaska could create a strong new tobacco control program and still have roughly $10 million or more per year available for other purposes. Moreover, by increasing its tax on cigarettes (currently 100¢ per pack), one of the best ways to reduce tobacco use, Alaska could secure even more funding for tobacco control and other worthwhile initiatives.

Directing Settlement Payments To Tobacco Control Will Not Waste Money. Tobacco control efforts throughout the country have been carefully researched and evaluated. Accordingly, Alaska could easily direct its settlement payments to support only those types of tobacco control initiatives that have established track records and follow available research findings on how to maximize beneficial results. To further enhance cost effectiveness, Alaska could also require that all of its new tobacco control activities be carefully monitored and evaluated, both to avoid fraud and abuse and to continually improve program performance.

Sources

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December 31, 1998

A-4

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4/6/99

FAIRBANKS
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Supplant the cigarettes

Officials from several states squeezed an immense settlement from tobacco companies last year using a cost argument. It costs government to treat people with tobacco ailments, the officials said, so government has a right to collect. Pay up, they told the tobacco companies, or we will pursue you as far as our courts can carry us. The companies paid.

Now the states, including Alaska, must decide what to do with the money. The honorable thing would be to spend a substantial chunk on an anti-tobacco campaign. If the state is so concerned about how much tobacco is costing our society that it will coerce millions from the tobacco companies, then the state ought to use that coerced money to reduce tobacco's use.

After all, that was the real goal of all this legal maneuvering, right? Let's stick to it.

The state of Alaska expects to receive a staggering $669 million from the settlement during the next 25 years. That's about $26 million a year on average.

Few in Juneau seem interested in applying any substantial chunk of this money to solving the problem, though. Legislators have proposed no increase in spending on tobacco education. The governor asked for $3 million.

A coalition of anti-smoking groups has created a plan that would spend about $8 million. They developed the plan by looking at what has worked in other states. It's a credible proposal and deserves support.

Of course, one can argue that the state could reasonably apply the tobacco money elsewhere in the budget. For example, it could help offset the increases in Medicaid spending. Some of those increases are presumably related to smoking (although some studies have concluded that the government's overall health care costs are actually reduced by smoking because smokers die sooner and faster).

But Medicaid just deals with the end result. If we were so concerned about smoking that we forced tobacco companies to pay government penalties, then we ought to make sure our government spends those penalties in a way that discourages that behavior. Anything less gives the government a bizarre financial interest in the continuance of such behavior.

Let's put our money where our mouths are. The dollars will supplant a few cigarettes.

To: Alaska Legislators

From: Citizens To Protect Kids from Tobacco

(Cancer Society
Heart Association
Lung Association
AK Native Health Board)

FY 1

Healthwise by Andrea Rock

Quitting Time for Smokers

New products and programs can quadruple your chances of success.

IF YOU'RE among the millions of smokers who resolve to quit each New Year's Day, only to find yourself a few days later dejectedly puffing away, take heart. A revolution in medical understanding of how smokers get hooked has led to new approaches to quitting that can increase your chances of success from the 5% typical of cold-turkey quitters to 20% or more. And at least part of the $206 billion tobacco settlement will go to funding programs to help you.

Recent studies provide clues to why breaking an addiction to nicotine is so difficult—even more difficult than kicking heroin or cocaine, according to Steven Adelman, medical director of substance abuse services for Harvard Vanguard Medical Associates. Nicotine stimulates brain cells to release a pleasure-inducing chemical called dopamine. "Each puff of a cigarette is a hit, a neurobiological mini-orgasm that is repeated millions of times, which explains why smokers yearn for that experience much longer than people addicted to many other pleasure-giving substances," Adelman says.

To still quitters' cravings, doctors and counselors have come to rely on various forms of nicotine replacement—from the now familiar skin patches to the cigarette-like Nicotrol Inhaler introduced last year. And the new drug Zyban targets the pathways of nicotine addiction in the brain, rather than replacing nicotine. The table at right details the cost, side effects and percentages of smokers who are still off cigarettes a year after quitting while using each of these products. Although you may see ads touting a product's success among those who've used it for a month or two, the one-year success rate is the best indicator of effectiveness, says Richard Merrick, whose 10-week smoking-cessation program at Kaiser Permanente in Harbor City, Calif. has an astounding 57% one-year quit rate.

How Zyban helps

Richard E. Hurt, director of the Mayo Clinic's $3,000 eight-day inpatient program, which has helped 43% of its severely addicted clients kick the habit, generally recommends that smokers start taking Zyban—the first pill to be approved by the FDA as a smoking-cessation aid—about a week before they plan to quit. The drug, which is also sold as an antidepressant called Wellbutrin SR (the initials stand for sustained release), lessens the desire to smoke by raising dopamine levels in the brain, just as cigarettes do. Zyban also whittles the average quitter's five-pound weight gain.

Zyban has no effect on 15% to 20% of smokers who try it, says Linda Ferry, a researcher at Loma Linda University School of Medicine, who first discovered that the drug helped people quit smoking. Experts suggest giving Zyban a one-month trial; most people take it for 12 weeks. Some health plans don't cover Zyban, but a few less than forthcoming smokers have gotten around that by asking doctors to diagnose them with depression and prescribe Wellbutrin SR, which is generally covered.

TOOLS FOR THE WOULD-BE NONSMOKER

Consult your doctor before using any nicotine-replacement product, particularly if you have heart disease or are taking medication for asthma or depression.

Product	How it works	One-year quit rate	Monthly cost
Nicorette gum	Average smoker chews six to nine pieces daily; each piece has 4mg of nicotine. Side effect: jaw pain	10% to 15%	$120
Nicotine-replacement patches (Nicoderm and Nicotrol are both sold over the counter; other brands are sold by prescription only)	Smokers apply skin patches daily, absorbing doses of nicotine that range from 7mg to 21mg. Side effect: skin irritation	10% to 15%	108
Nicotrol Nasal Spray (prescription only)	Delivers 0.5mg per spray; can be used daily for up to six months. Nicotine hits bloodstream faster than gum, patch or inhaler.	10% to 15%	120
Nicotrol Inhaler (prescription only)	Patient puffs on plastic mouthpiece containing nicotine cartridge to receive 4mg of nicotine, or about one-third the blood level delivered by a cigarette.	10% to 15%	160
Zyban (prescription only)	Two tablets a day changes brain chemistry to relieve cravings. Also reduces weight gain that occurs after quitting. Side effects: dry mouth, insomnia and a one in 1,000 risk of seizure	23%	$84 to $100

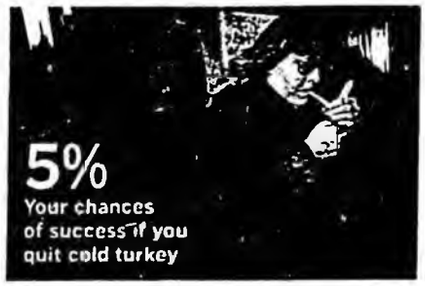
Sources: Sol Schiffman of the University of Pittsburgh (nicotine-replacement success rates), McNeil Consumer Products, SmithKline and Glaxo Wellcome

Jessica Wecker (5)

Healthwise *continued*

Because Zyban carries a slight (one in 1,000) risk of seizures, Harvard Vanguard's Adelman prefers starting patients off with a nicotine patch. But for smokers who find they crave the ritual and hand-to-mouth activity of smoking, nicotine gum, the inhaler or nasal spray may work better, he says. The nasal spray gets nicotine into your system fastest, while the inhaler most closely replicates the act of smoking. The gum's advantage is that it's available without a prescription; most smokers will need the 4mg version.

To help the most intractable smokers, specialists now combine Zyban with nicotine-replacement products, using double patches or patches plus gum or an inhaler. "Most patches deliver only half the nicotine a smoker would get from one pack a day. So some may find nicotine replacement hasn't worked well simply because they're being underdosed," says the Mayo Clinic's Hurt. Some doctors keep patients on the products for several months rather than the 10 to 12 weeks most manufacturers recommend.



Christopher Smith/Impact Visuals

But to avoid dangerously high blood pressure or nicotine overdosing (40mg to 60mg is considered lethal, but individual tolerances can vary), combining products or straying from dosage instructions should be done only under a doctor's supervision. And while nicotine replacement is safer than smoking, new studies from the University of Minnesota suggest that using nicotine replacement for more than three to six months may damage blood and lung cells, possibly leading to artery disease, bronchitis or both.

Why you may need a support group

"Smoking is a way of coping with stress as well as of obtaining pleasure, so break-

ing that psychological addiction is just as crucial as eliminating the physical one," says Bonnie Spring, a University of Illinois–Chicago psychologist whose programs achieve long-term quit rates of 40% or more. Adding some form of counseling to your quitting plan is essential, says Richard Merrick. Participants in his highly successful Kaiser Permanente program attend Nicotine Anonymous meetings (415-750-0328). Merrick says that the group, which applies Alcoholics Anonymous principles to smokers, is the be... of the many low-cost or free groups because it offers long-term support. If Nicotine Anonymous doesn't meet in your area, both the American Cancer Society (800-227-2345) and the American Lung Association (800-586-4872) sponsor counseling programs of four to eight weeks' duration.

What's coming

In the research pipeline now are several drugs that, like Zyban, target brain chemistry. There are also novel forms of nicotine replacement, including an under-the-tongue tablet and a lollipop. The market for these drugs is expanding at a rapid pace. In 1998, sales of over-the-counter nicotine-replacement products exceeded $568 million, according to Information Resources, a Chicago-based marketing research firm. That's nearly double total sales in 1996, when these products first became available over the counter. Prescriptions are soaring too. Sales for the 12 months that ended September 1998 totaled $184.4 million, up 154% from the previous year, according to IMS Health, a health-care information company in Plymouth Meeting, Pa.

Using smoking-cessation aids as part of a plan you develop with an experienced doctor makes you more likely to reap their full benefits. First, though, talk to your health plan. About 75% of HMOs now cover smoking-cessation products and programs, which may be provided by the plan itself. You can also locate a physician who specializes in smoking cessation by calling the 3,200-member American Society of Addiction Medicine (301-656-3920).

Source: Campaign for Tobacco-Free Kids

Why Alaska Should Use Its Tobacco Settlement Money To Support A New Comprehensive Statewide Tobacco Control Strategy

Alaska has already begun deciding how to use the millions of dollars it will receive each year from the settlement agreement with the tobacco companies. While some state legislators and others might be tempted to direct these new funds to a tax cut or to other favorite projects or causes, the arguments for directing a substantial portion of the settlement payments to establish a comprehensive statewide tobacco control strategy are overwhelming. It would substantially reduce smoking and other tobacco use, save thousands of lives and millions of dollars, dramatically improve public health, and do more to help Alaska and its citizens than any other option.

Tobacco Company Payments Should Go To Fight Tobacco Company Harms. The tobacco companies' payments to Alaska for past tobacco-related harm to the state should be used to reduce the amount of damage tobacco use will cause Alaska and its citizens in the future -- and that means using settlement funds to sharply curtail smoking and other tobacco use throughout the state, especially among children.

The Public Supports Using Tobacco Settlement Money For Tobacco Control. In a pre-election poll of likely Alaska voters, 77% said that about half or more of the settlement funds should be spent to reduce smoking among kids (with only 1% saying that none of the funds should be so used). Similarly, in a recent nationwide poll, 84 percent of the respondents favored spending the money their state receives to reduce tobacco use among kids, including more than two-thirds (69%) who "strongly favor" spending the money for this purpose.

The Smoking Problem Is Big And Getting Worse. Approximately 27 percent of adult men and 25 percent of adult women in Alaska are current smokers, along with 36 percent of all high school students. While adult smoking has generally been declining in recent years, the number of kids who are smoking has been increasing steadily throughout the 1990s, and has only just experienced a small decline. Underage smoking remains at historically high levels, and over the past 10 years the number of kids under 18 who become daily smokers each year has increased by more than 70 percent. In Alaska alone, more than 4,000 kids under 18 become new daily smokers each year.

A Comprehensive Statewide Tobacco Control Strategy Would Dramatically Reduce Smoking And Other Tobacco Use In Alaska. California and Massachusetts have already initiated tobacco control campaigns that have reduced overall smoking levels within their borders at a faster rate than elsewhere in the country. Similarly, while youth smoking rates were going up nationwide, in California and Massachusetts they either declined or increased much more slowly -- despite significant reductions to both states' tobacco control efforts and despite aggressive tobacco company efforts to dampen the impact of the state programs.

New Tobacco Control Spending Will Save Lives. Tobacco use is responsible for more deaths than alcohol, auto accidents, AIDS, suicides, murders, and illegal drugs combined. Each year, about 400 people die from smoking-related causes in Alaska, and countless others suffer from tobacco-related disease and distress, including many of those exposed to second hand smoke. If current smoking trends are not reversed, roughly 17,000 of the children currently alive in the state will eventually die from smoking-related causes. Directing tobacco settlement monies to tobacco control can reduce this unnecessary disease, misery, and death -- and there is no better investment Alaska can make to save lives and improve public health.

New Tobacco Control Spending Will Save Alaska Money. Public and private direct expenditures in Alaska to treat health problems caused by smoking annually total roughly $150 million, with the state government paying approximately $20 million every year in cigarette-related Medicaid expenditures. Alaska and its citizens annually pay millions more for health care relating to smokeless tobacco use, cigar and pipe smoking, and exposure to second hand smoke. Beyond these direct health expenditures are tobacco-related labor costs and lost productivity (e.g., tobacco-related sick days); damage and loss from cigarette-related fires; and tobacco-related maintenance and cleaning expenses. An aggressive statewide tobacco control strategy would reduce all of these tobacco-related costs and save the state, its businesses, and its citizens many millions of dollars each and every year.

Nickel And Diming The Problem Won't Work. Significantly reducing tobacco use in Alaska requires substantial investment in a sustained and comprehensive multi-year tobacco control strategy. Anything less will not effectively counter the addictive power of nicotine or the tobacco companies' advertising and marketing expenditures (more than $11 million per year in Alaska). Existing tobacco control efforts throughout the country show that the best way to reduce tobacco use, other than raising prices, is to take full advantage of a wide range of proven effective measures, including counter advertising, school and community-based prevention and cessation programs, the enhanced enforcement of laws prohibiting the sale of tobacco products to kids, and the firm maintenance of smoke-free workplaces and public areas. While any one of these tobacco control measures can reduce tobacco use by itself, they work much more powerfully and effectively when done together.

Relying On The Settlement Agreement's Tobacco Control Provisions Won't Work. Although the tobacco settlement contains some useful restrictions on tobacco marketing, they will not, by themselves, significantly hinder the tobacco industry's ability to market to kids. Similarly, the new national public education campaign financed by the multi-state settlement can significantly reduce tobacco use only if it is accompanied by strong state tobacco control efforts. Put simply, the tobacco settlement can dramatically cut tobacco use in Alaska only if the state uses its tobacco company payments to finance new tobacco control initiatives.

If The State Doesn't Do It, No One Else Will. Because of a special provision in the settlement agreement, until 2003 the tobacco companies' payments to Alaska will be reduced by any new federal funding made available to the state for tobacco control efforts that comes from an increase in the federal tobacco tax or from any other new charges against the tobacco companies. Consequently, it is highly unlikely that Congress will direct any new federal tobacco control funding to Alaska for some time.

Adequately Funding A Comprehensive Statewide Tobacco Control Strategy Would Still Leave Plenty Of Settlement Funding For Other Purposes. The U.S. Centers for Disease Control and Prevention estimates that adequately funding a comprehensive tobacco control effort in Alaska requires $8 to $17 million per year in new funding. Accordingly, Alaska could create a strong new tobacco control program and still have roughly $10 million or more per year available for other purposes. Moreover, by increasing its tax on cigarettes (currently 100¢ per pack), one of the best ways to reduce tobacco use, Alaska could secure even more funding for tobacco control and other worthwhile initiatives.

Directing Settlement Payments To Tobacco Control Will Not Waste Money. Tobacco control efforts throughout the country have been carefully researched and evaluated. Accordingly, Alaska could easily direct its settlement payments to support only those types of tobacco control initiatives that have established track records and follow available research findings on how to maximize beneficial results. To further enhance cost effectiveness, Alaska could also require that all of its new tobacco control activities be carefully monitored and evaluated, both to avoid fraud and abuse and to continually improve program performance.

Sources

Polling data on using tobacco settlement payments for new tobacco control efforts from state-specific and national polls of likely voters conducted for the National Center for Tobacco-Free Kids by Mason Dixon Political/Media Research in early October 1998, and by Market Facts' TeleNation in early November 1998, respectively.

For state-specific data on deaths caused by smoking, smoking and smokeless tobacco use rates, and other tobacco-related information, see Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, State Tobacco Control Highlights 1997 (1998) [http://www.cdc.gov/nccdphp/osh/statehi/statehi.htm]. See also, CDC, "State-Specific Prevalence Among Adults of Current Cigarette Smoking and Smokeless Tobacco Use and Per Capita Tax-Paid Sales of Cigarettes – United States, 1997," Morbidity and Mortality Weekly Report 47(43): 922-926 (November 6, 1998); "1995 Alaska Youth Risk Behavior Survey"; CDC, "State-Specific Prevalence of Cigarette Smoking Among Adults, and Children's and Adolescents' Exposure to Environmental Tobacco Smoke – United States 1996," Morbidity and Mortality Weekly Report 46(44): 1038-1043 (November 7, 1997); CDC, "Smoking Attributable Mortality and Years of Potential Life Lost – United States, 1984" (with editors update for 1990-1994), Morbidity and Mortality Weekly Report 46(20): 444-451 (May 23, 1997). For projected smoking deaths among today's youth, see CDC, "Projected Smoking-Related Deaths Among Youth – United States," Morbidity and Mortality Weekly Report 45(44): 971-974 (November 8, 1996).

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For additional information on tobacco-related costs, see U.S. Department of the Treasury, The Economic Costs of Smoking in the U.S. and the Benefits of Comprehensive Tobacco Legislation (1998) [http://www.treas.gov/press/releases/docs/tobacco.pdf]; F.J. Chaloupka and K.E. Warner, "The Economics of Smoking," in J. Newhouse and A. Culyer (eds), The Handbook of Health Economics (in press); CDC, Morbidity and Mortality Weekly Report 46(44) (November 7, 1997); CDC, Making Your Workplace Smokefree: A Decision Maker's Guide (1996); D. Mudarri, "The Costs and Benefits of Smoking Restrictions: An Assessment of the Smoke-Free Environment Act of 1993 (H.R. 3434)," U.S. Environmental Protection Agency report submitted to the Subcommittee on Health and the Environment, Committee on Energy and Commerce, U.S. House of Representatives (April 1994); P. Brigham and A. McGuire, "Progress Toward a Fire-Safe Cigarette," Journal of Public Health Policy 16(4): 433-439 (1995); E.K. Adams and C.L. Melvin, "Costs of Maternal Conditions Attributable to Smoking During Pregnancy," American Journal of Preventive Medicine 15(3): 212-19 (October 1998); CDC, "Medical Care Expenditures Attributable to Cigarette Smoking During Pregnancy," Morbidity and Mortality Weekly Report 46(44) (November 7, 1997); J.J. Stoddard and B. Gray, "Maternal Smoking and Medical Expenditures for Childhood Respiratory Illness," American Journal of Public Health 87(2): 205-209 (February 1997).

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For evaluations of the Massachusetts and California comprehensive state tobacco control strategies, see T. Pechacek and M. Eriksen, Office of Smoking and Health, CDC, "Efficacy of Comprehensive Tobacco Control Programs: California and Massachusetts" (in press); J. Pierce, et al., "Has the California Tobacco Control Program Reduced Smoking?," Journal of the American Medical Association 280(10): 893-899 (September 9, 1998); T. Hu, et al., "Reducing Cigarette Consumption in California: Tobacco Taxes vs. an Anti-Smoking Media Campaign," American Journal of Public Health 85: 1218-1222 (September 1995); Abt Associates, Independent Evaluation of the Massachusetts Tobacco Control Program: Fourth Annual Report, January 1994 to June 1997 (1998); J.P. Pierce, et al., Tobacco Control in California: Who's Winning the War? An Evaluation of the Tobacco Control Program 1989-1996 (Univ. of California, San Diego 1998).

CDC estimates on how much Alaska would have to spend to implement a comprehensive statewide tobacco control program are from Office on Smoking and Health, CDC, "State Comprehensive Tobacco Prevention and Control Guidelines" (October 1998). Information on the states' tobacco settlement receipts from the website of the National Association of Attorneys General http://www.naag.org/, and related links.

December 31, 1998

A-4

Sam Bishop, Opinion Page Editor; 459-7574; e-mail: letters@newsminer.c

4/6/99

FAIRBANKS
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MARILYN ROMANO, General Manager
SAM BISHOP, Editorial Page Editor

Supplant the cigarettes

Officials from several states squeezed an immense settlement from tobacco companies last year using a cost argument. It costs government to treat people with tobacco ailments, the officials said, so government has a right to collect. Pay up, they told the tobacco companies, or we will pursue you as far as our courts can carry us. The companies paid.

Now the states, including Alaska, must decide what to do with the money. The honorable thing would be to spend a substantial chunk on an anti-tobacco campaign. If the state is so concerned about how much tobacco is costing our society that it will coerce millions from the tobacco companies, then the state ought to use that coerced money to reduce tobacco's use.

After all, that was the real goal of all this legal maneuvering, right? Let's stick to it.

The state of Alaska expects to receive a staggering $669 million from the settlement during the next 25 years. That's about $26 million a year on average.

Few in Juneau seem interested in applying any substantial chunk of this money to solving the problem, though. Legislators have proposed no increase in spending on tobacco education. The governor asked for $3 million.

A coalition of anti-smoking groups has created a plan that would spend about $8 million. They developed the plan by looking at what has worked in other states. It's a credible proposal and deserves support.

Of course, one can argue that the state could reasonably apply the tobacco money elsewhere in the budget. For example, it could help offset the increases in Medicaid spending. Some of those increases are presumably related to smoking (although some studies have concluded that the government's overall health care costs are actually reduced by smoking because smokers die sooner and faster).

But Medicaid just deals with the end result. If we were so concerned about smoking that we forced tobacco companies to pay government penalties, then we ought to make sure our government spends those penalties in a way that discourages that behavior. Anything less gives the government a bizarre financial interest in the continuance of such behavior.

Let's put our money where our mouths are. The dollars will supplant a few cigarettes.

To: Alaska legislators

From: Citizens To Protect Kids from Tobacco

(Cancer Society
Heart Association
Lung Association
AK Native Health Board)

FY 1

Healthwise by Andrea Rock

Quitting Time for Smokers

New products and programs can quadruple your chances of success.

IF YOU'RE among the millions of smokers who resolve to quit each New Year's Day, only to find yourself a few days later dejectedly puffing away, take heart. A revolution in medical understanding of how smokers get hooked has led to new approaches to quitting that can increase your chances of success from the 5% typical of cold-turkey quitters to 20% or more. And at least part of the $206 billion tobacco settlement will go to funding programs to help you.

Recent studies provide clues to why breaking an addiction to nicotine is so difficult—even more difficult than kicking heroin or cocaine, according to Steven Adelman, medical director of substance abuse services for Harvard Vanguard Medical Associates. Nicotine stimulates brain cells to release a pleasure-inducing chemical called dopamine. "Each puff of a cigarette is a hit, a neurobiological mini-orgasm that is repeated millions of times, which explains why smokers yearn for that experience much longer than people addicted to many other pleasure-giving substances," Adelman says.

To still quitters' cravings, doctors and counselors have come to rely on various forms of nicotine replacement—from the now familiar skin patches to the cigarette-like Nicotrol Inhaler introduced last year. And the new drug Zyban targets the pathways of nicotine addiction in the brain, rather than replacing nicotine. The table at right details the cost, side effects and percentages of smokers who are still off cigarettes a year after quitting while using each of these products. Although you may see ads touting a product's success among those who've used it for a month or two, the one-year success rate is the best indicator of effectiveness, says Richard Merrick, whose 10-week smoking-cessation program at Kaiser Permanente in Harbor City, Calif. has an astounding 57% one-year quit rate.

How Zyban helps

Richard E. Hurt, director of the Mayo Clinic's $3,000 eight-day inpatient program, which has helped 43% of its severely addicted clients kick the habit, generally recommends that smokers start taking Zyban—the first pill to be approved by the FDA as a smoking-cessation aid—about a week before they plan to quit. The drug, which is also sold as an antidepressant called Wellbutrin SR (the initials stand for sustained release), lessens the desire to smoke by raising dopamine levels in the brain, just as cigarettes do. Zyban also whittles the average quitter's five-pound weight gain.

Zyban has no effect on 15% to 20% of smokers who try it, says Linda Ferry, a researcher at Loma Linda University School of Medicine, who first discovered that the drug helped people quit smoking. Experts suggest giving Zyban a one-month trial; most people take it for 12 weeks. Some health plans don't cover Zyban, but a few less than forthcoming smokers have gotten around that by asking doctors to diagnose them with depression and prescribe Wellbutrin SR, which is generally covered.

TOOLS FOR THE WOULD-BE NONSMOKER

Consult your doctor before using any nicotine-replacement product, particularly if you have heart disease or are taking medication for asthma or depression.

Product	How it works	One-year quit rate	Monthly cost
Nicorette gum	Average smoker chews six to nine pieces daily; each piece has 4mg of nicotine. Side effect: jaw pain	5% to 15%	$120
Nicotine-replacement patches (Nicoderm and Nicotrol are both sold over the counter; other brands are sold by prescription only)	Smokers apply skin patches daily, absorbing doses of nicotine that range from 7mg to 21mg. Side effect: skin irritation	10% to 15%	108
Nicotrol Nasal Spray (prescription only)	Delivers 0.5mg per spray; can be used daily for up to six months. Nicotine hits bloodstream faster than gum, patch or inhaler.	10% to 15%	120
Nicotrol Inhaler (prescription only)	Patient puffs on plastic mouthpiece containing nicotine cartridge to receive 4mg of nicotine, or about one-third the blood level delivered by a cigarette.	10% to 15%	160
Zyban (prescription only)	Two tablets a day changes brain chemistry to relieve cravings. Also reduces weight gain that occurs after quitting. Side effects: dry mouth, insomnia and a one in 1,000 risk of seizure	23%	$84 to $100

Sources: Sol Schiffman of the University of Pittsburgh (nicotine-replacement success rates), McNeil Consumer Products, SmithKline and Glaxo Wellcome

Jessica Wachter (5)

Healthwise *continued*

Because Zyban carries a slight (one in 1,000) risk of seizures, Harvard Vanguard's Adelman prefers starting patients off with a nicotine patch. But for smokers who find they crave the ritual and hand-to-mouth activity of smoking, nicotine gum, the inhaler or nasal spray may work better, he says. The nasal spray gets nicotine into your system fastest, while the inhaler most closely replicates the act of smoking. The gum's advantage is that it's available without a prescription; most smokers will need the 4mg version.

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Christopher Smith/Impact Visuals

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SUGGESTED SCRIPT: HB37
HOUSE FINANCE COMMITTEE
April 16, 1999

AGENDA:

HB 37 – Adds smoking cessation component to DHSS

1. Introduction of Bill - Rep. Norman Rokeberg (5 min.)

2. **Adopt CS**

3. Anne Marie Holen – Alaska Native Health Board, with video; Danny McGoldrick, Campaign for Tobacco Free Kids (20 min.)

4. Commissioner Karen Perdue, Dept. of Health and Social Services (5 min.)

5. 4 people to testify via teleconference (2 min. each – Anchorage & F.B.)

6. Doug Gardner will be available for questions, if needed.

About 20 minutes for questions

CONSIDER AMENDMENT:

AMENDMENT 1:

❖ Page 1, line 12:
Delete "does not comply with all of"
Insert "differs in any respect from"

Reason: There has been an argument that if the packs have any warning at all, they should be allowed. Wording may differ and the rotating warnings would not be utilized as required by the FTC.

- Page 2, line 5:
  Delete "masking"
  Insert "adding, masking,"

  Reason: Covers all possibilities for tampering with the warning label.

- Page 2, line 10:
  Delete "may"
  Insert "shall"

  Reason: There should be no question about how the confiscated product will be disposed. Reselling the cigarettes should not be an option.

Thank you,
Representative Rokeberg

1-LS0247\H.1
Ford
4/10/99

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE ROKEBERG

TO: CSHB 37(HES)

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EXPLANATION OF CHANGES:

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Page 2, line 10 - There should be no question about how the confiscated product will be disposed. Reselling the cigarettes should not be an option.

Rep. Rokeberg

Citizens To Protect Kids from Tobacco

1057 W. Fireweed Lane, Suite 204 • Anchorage, Alaska 99503 • (907) 277-8696 • Fax: (907) 263-2073

March 8, 1999

Dear Legislators:

This Plan for the Future was developed by the Alaska Tobacco Control Alliance to provide a blueprint for dramatically reducing tobacco-caused addiction, disease, and death in Alaska. It incorporates proven strategies and expert recommendations for an effective, comprehensive statewide tobacco control program.

During the Hickel Administration, Alaska adopted a goal to reduce smoking prevalence to no more than 15% by the year 2000. We're not going to reach that goal, not in this century. But that doesn't mean we should give up. As Dr. Michael Eriksen, director of the CDC Office on Smoking and Health said, ***"The challenge is to put into place what we know works. To do anything less is to turn our backs on the health of future generations."***

Another reason not to give up is because we now have the resources to fight tobacco and win. Those resources are in the form of tobacco industry payments to Alaska, amounting to over $25 million a year for 25 years. With this money, we have a historic opportunity to make sure that the past does not become the future.

Citizens To Protect Kids from Tobacco supports using at least 30% of the tobacco settlement payments to fund an ongoing, comprehensive tobacco control program. We ask that you consider the following points:

Tobacco company payments should go to fight tobacco company harms. The tobacco companies' payments to Alaska for past tobacco-related harm to the state should be used to reduce the amount of damage tobacco use will cause Alaska and its citizens in the future.

The public supports using tobacco settlement money for tobacco control. In a pre-election poll of likely Alaska voters, 77% said that about half or more of the settlement funds should be spent on programs to reduce smoking.

Tobacco is the biggest killer in Alaska. One out of five deaths in the state are caused by smoking. More than 4,000 Alaskan kids under age 18 become new daily smokers each year.

A comprehensive statewide tobacco control strategy would dramatically reduce smoking and other tobacco use in Alaska. We know from the experience in other states that investing substantial resources in tobacco prevention and cessation programs pays off. The money is not wasted.

New tobacco control spending will save Alaska money. Tobacco use costs the Alaskan economy $150 million each year in direct health care costs alone. This figure is

conservative, since it covers only those health care costs among adults caused by their own smoking. It doesn't include health costs related to secondhand smoke exposure or health costs for newborns and infants caused by their mothers' smoking during pregnancy.

Relying on the settlement agreement's tobacco control provisions won't work. The settlement's public health provisions are weak and are not expected to reduce tobacco use significantly. Put simply, the tobacco settlement can dramatically cut tobacco use in Alaska only if the state uses its tobacco company payments to finance new tobacco control initiatives.

Nickel and diming the problem won't work. Significantly reducing tobacco use in Alaska requires substantial investment in a sustained and comprehensive multi-year tobacco control strategy. Anything less will not effectively counter the addictive power of nicotine or tobacco company marketing.

Existing tobacco control efforts throughout the country show that the best way to reduce tobacco use, other than raising prices, is to take full advantage of a wide range of proven effective measures, including counteradvertising, school and community-based prevention and cessation programs, the enhanced enforcement of laws prohibiting the sale of tobacco products to kids, and the firm maintenance of smoke-free workplaces and public places. While any one of these tobacco control measures can reduce tobacco use by itself, they work much more powerfully and effectively when done together.

Alaskans understand where this money is coming from and how it should be spent. We have been seeing the same level of support for a comprehensive tobacco control program that we saw with the tobacco tax. Alaskans want to see state government take on the tobacco industry. If we invest the resources we need to do it right, we all win. Let's make smoking history.

Sincerely,

Diana Kuhns
Chief Operating Officer
American Cancer Society
Western Pacific Division

Craig Harpel
Executive Director
American Heart Association
Alaska Region

Christie McIntire
Executive Director
American Lung Association of Alaska

Leo J. Morgan
President and CEO
Alaska Native Health Board