

ALASKA LEGISLATURE

1917

HOUSE and SENATE FINANCE COMMITTEE FILES, 1999 - 2000



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.*

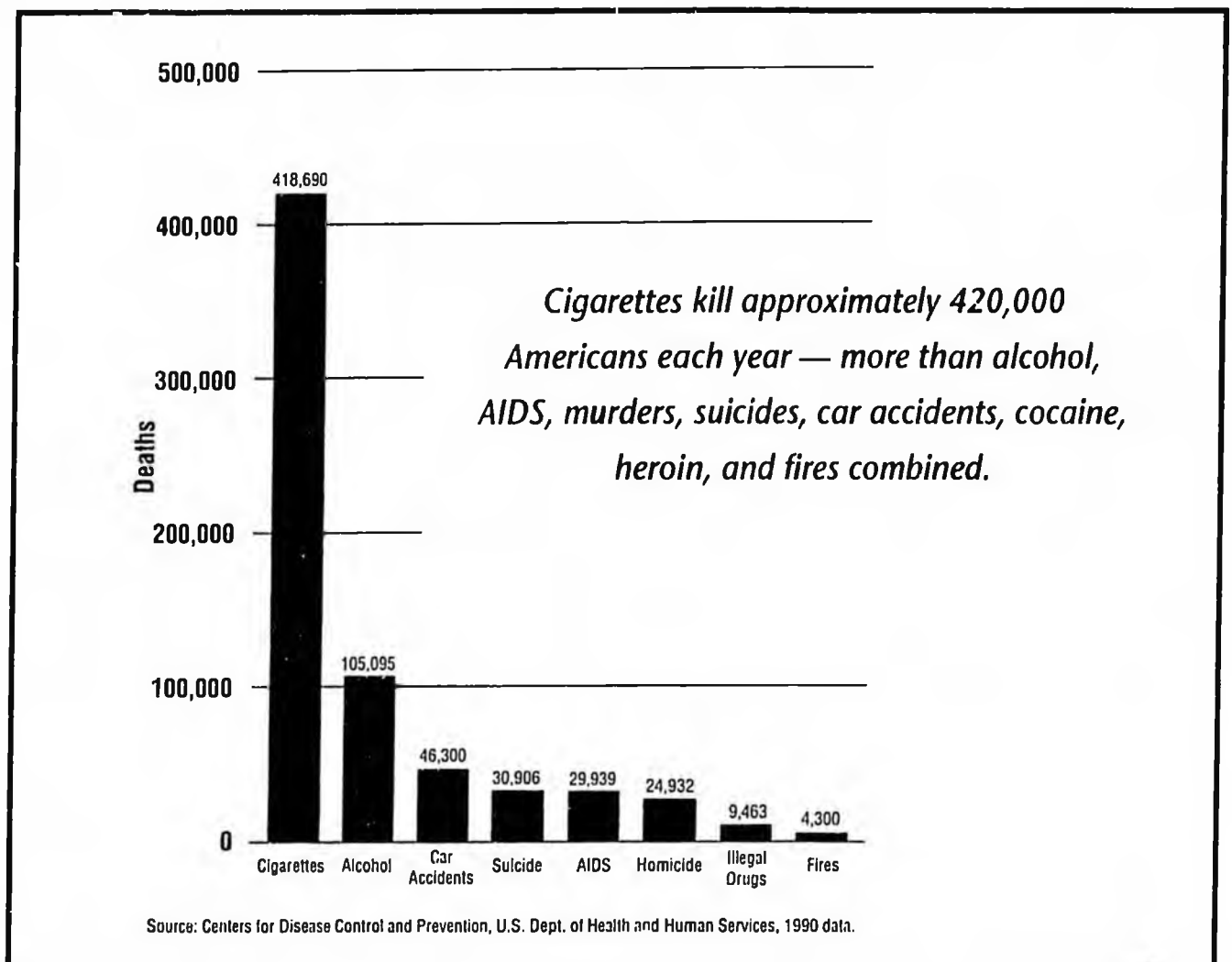
- **Smoking is the leading cause of preventable death** in Alaska, as in the U.S. as a whole.²
- **Tobacco is responsible for one out of five deaths** in Alaska, or almost 500 deaths a year. From 1992-1994, smoking accounted for 19.8% of all deaths in Alaska.³
- **Almost 14,000 Alaskans under the age 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.
- **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

TOTAL NUMBER OF DEATHS AND ESTIMATED SMOKING-RELATED DEATHS IN ALASKA, 1992-94⁹

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%

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



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.**
- **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

"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

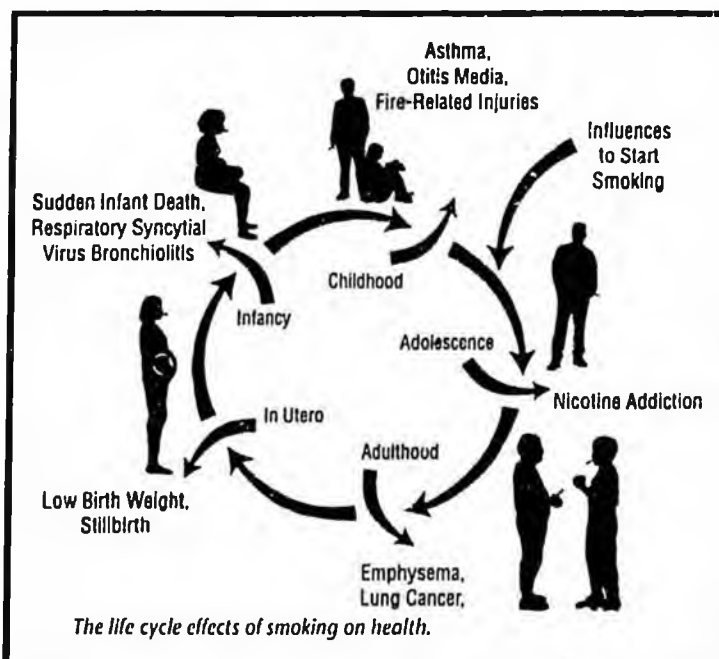


Figure 2. The life cycle of the effects of smoking on health.¹⁷

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
- **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.

"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

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.

- **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.
- **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 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

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

1981 Philip Morris internal document

THE TOBACCO INDUSTRY

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

message on poster
California Dept. of Health Services

*Profits
premised on
addiction,
resulting in
disease
and death.*

- 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.
- 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
- 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.

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.

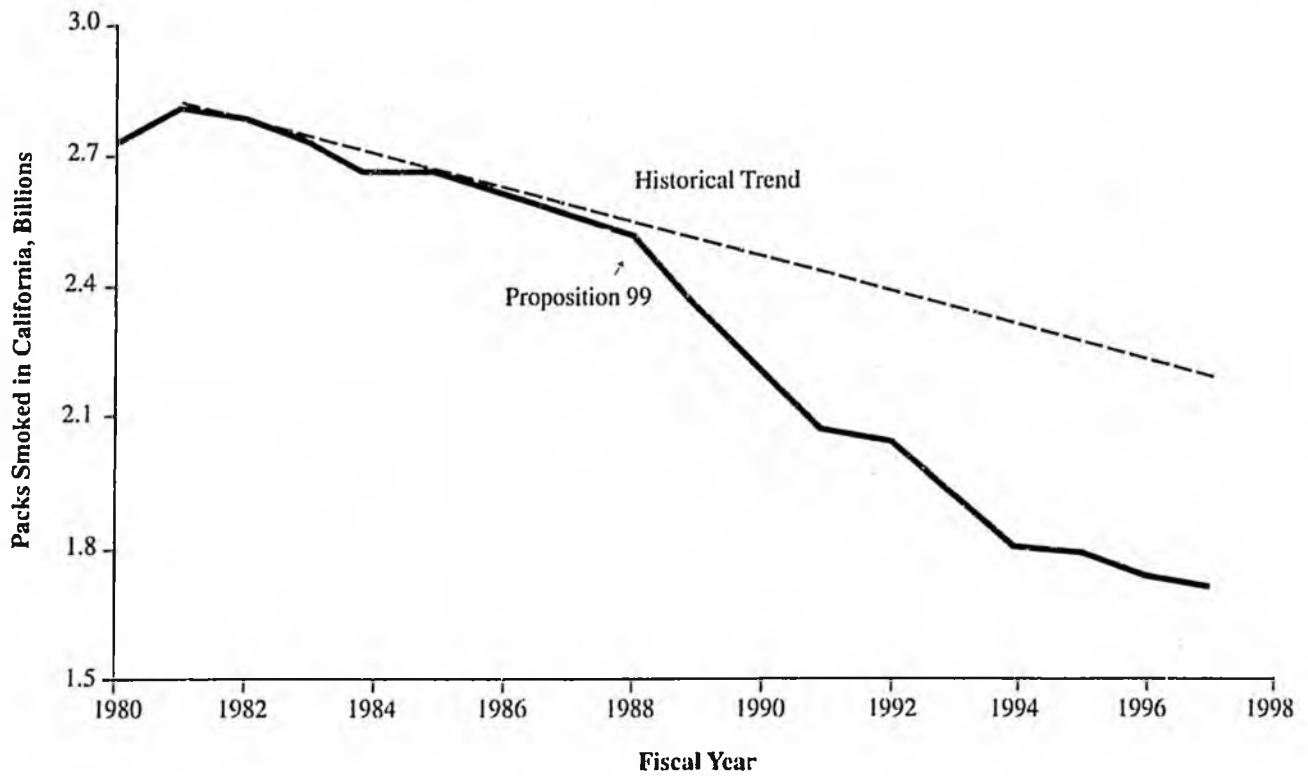
Such an effort must involve kids, parents, teachers, health workers, law enforcement personnel, employers, and policy makers. Community-based projects, school-based projects, and state-of-the art cessation services are key components. Equally critical to the overall program is a sophisticated, high-profile 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

“The most important public health issue of our time.”

C. Everett Koop, MD

DECLINE OF TOBACCO CONSUMPTION IN CALIFORNIA, 1980-1997⁴⁶



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.

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 ..	<u>\$650,000</u>
TOTAL	\$8.2 million

*“We must
not allow
the past
to become
the future.”*

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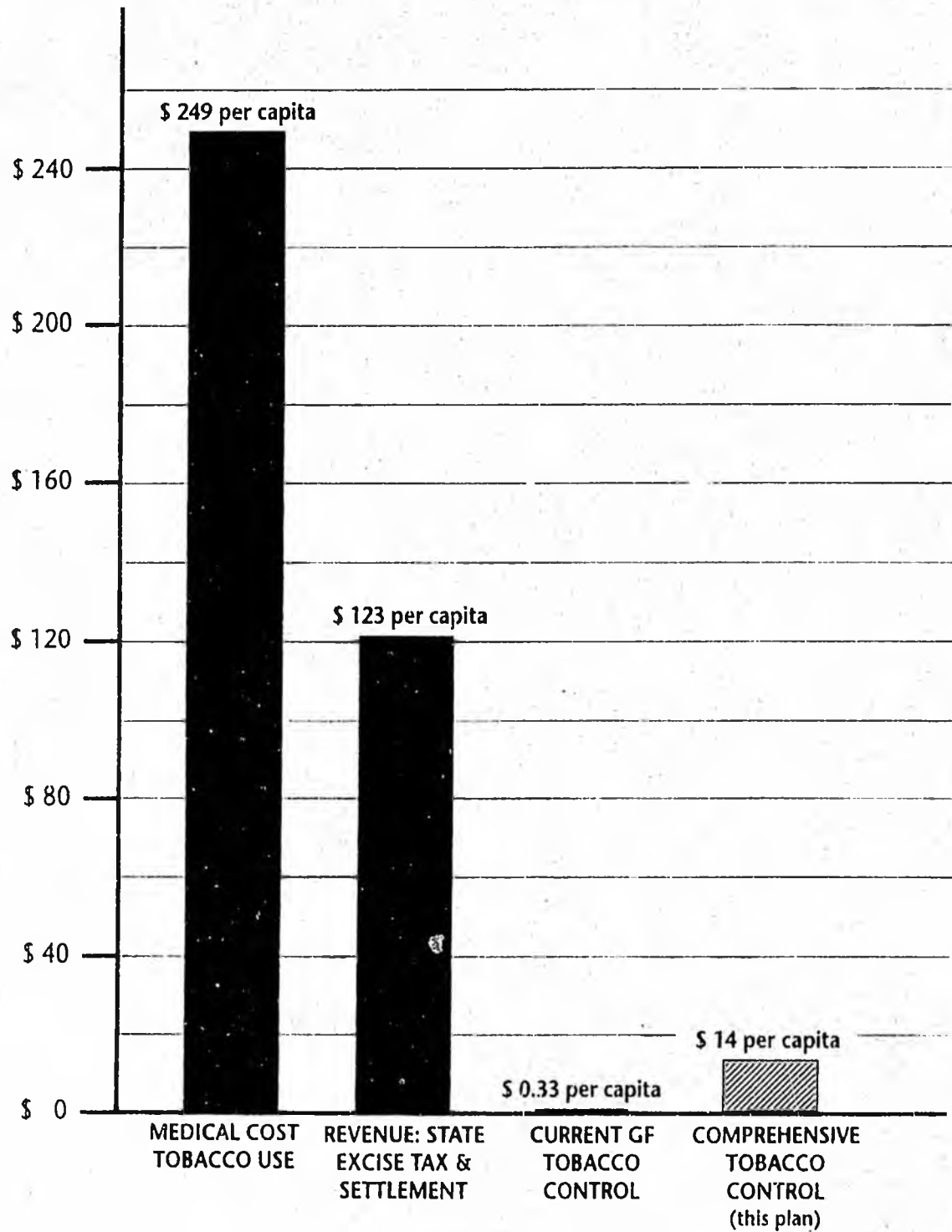
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**ALASKA: THE COST OF TOBACCO USE, STATE TOBACCO REVENUE,
CURRENT GENERAL FUND SPENDING for TOBACCO CONTROL,
and PROPOSED SPENDING, ATCA PLAN
(annual, per capita)**



CORRECTION

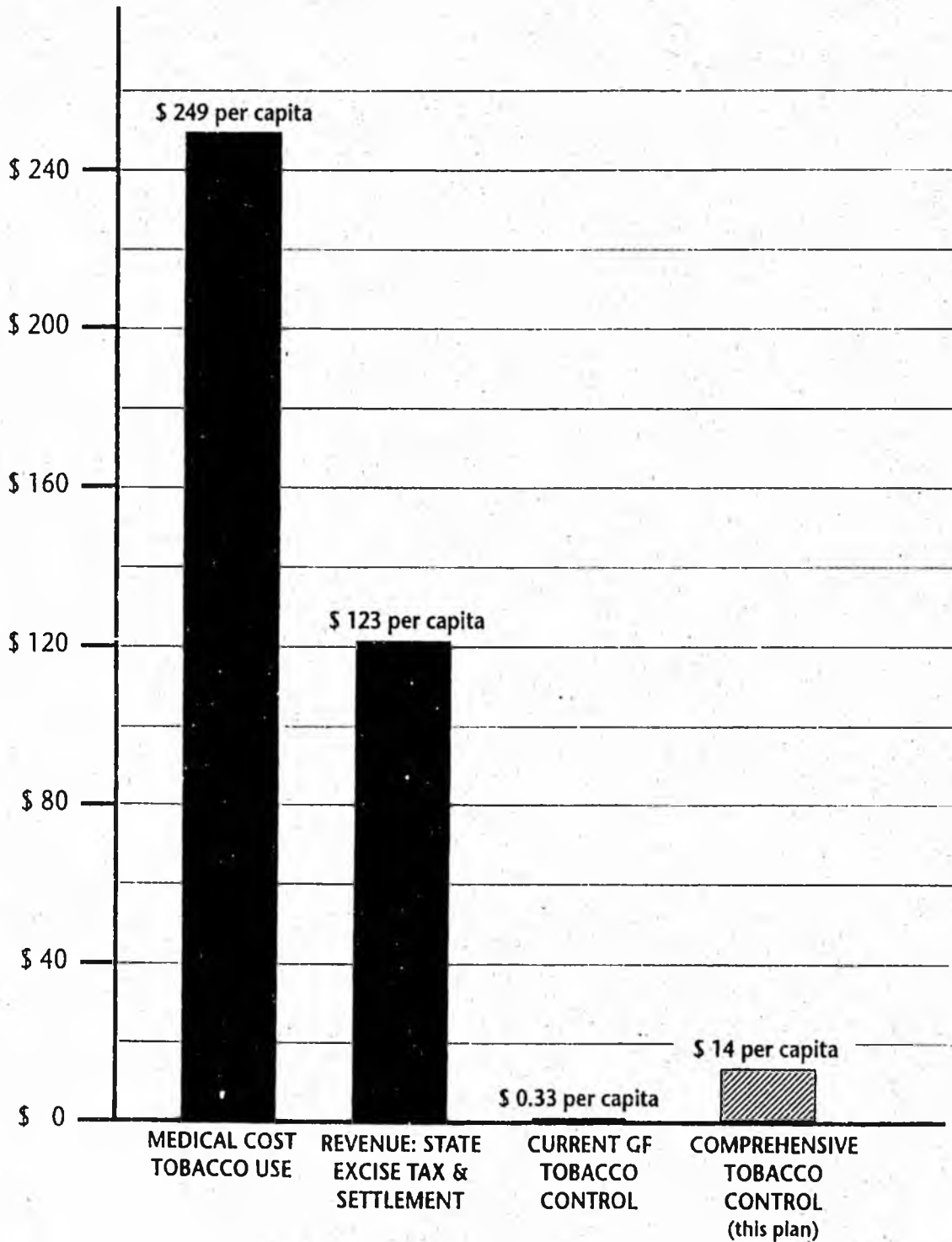
THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION



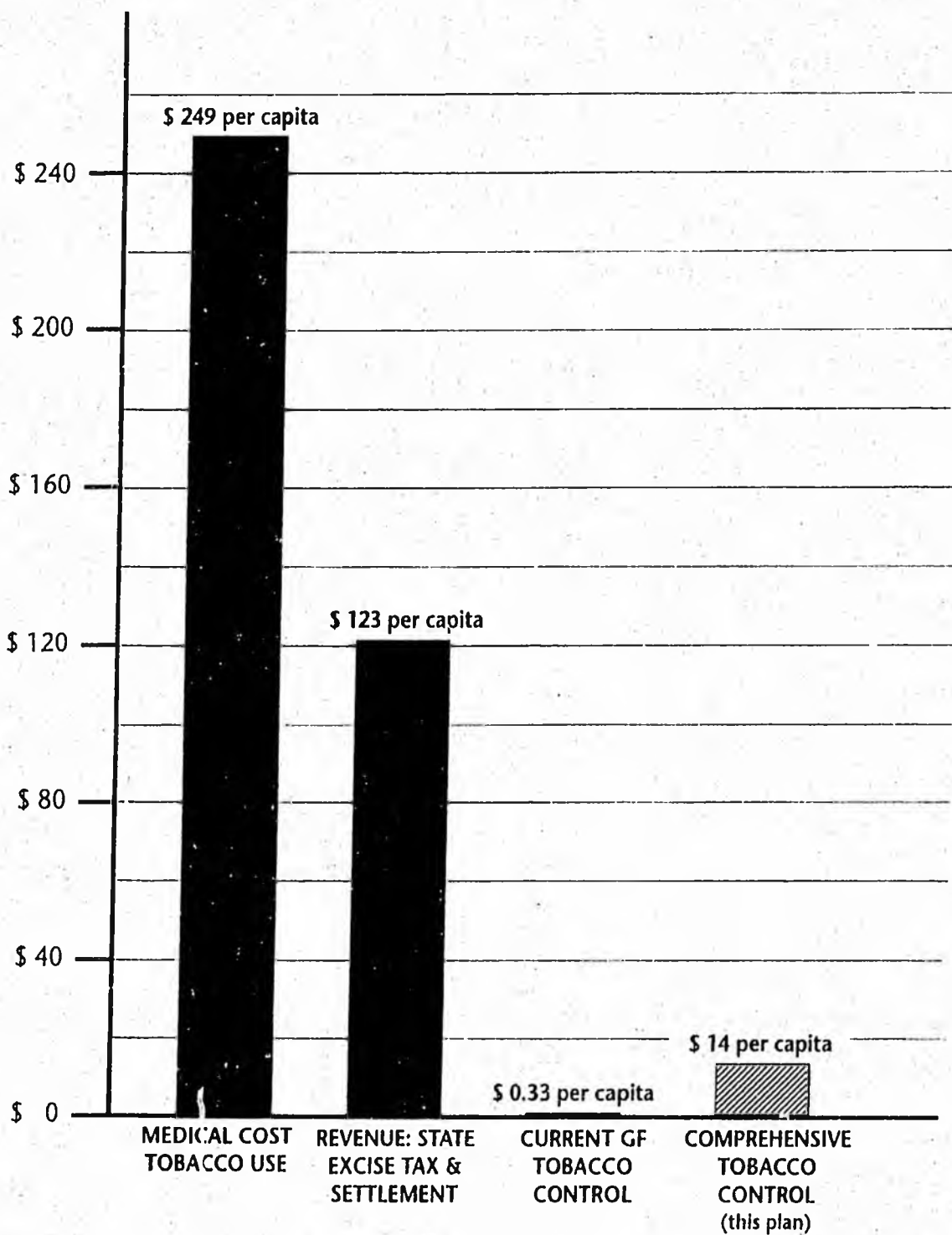
Rev. 6/98

Central Microfilm Services
Department of Education & Early Development
State of Alaska

**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) _____

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

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
<u>William Williams</u>	X			
<u>Walter Austerman</u>			X	
<u>Ch. Blunt</u>			X	
<u>Ben Grussendorf</u>			X	
<u>Don Kohring</u>				X
<u>John Mulder</u>		X		
<u>Therriault</u>			X	
<u>Davis</u>			X	

CHAIR'S SIGNATURE

Therriault Ch. Blunt

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. CSHB 37 (FIN)

Revision Date: _____
Title: Relating to Smoking Education and Cessation

Dept. Affected DISS
BRU State Health Services
Component Tobacco Prevention and Control

Sponsor: Rokeberg
Requester: _____

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						
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CHANGE IN REVENUES []						
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FUND SOURCE

(Thousands of Dollars)

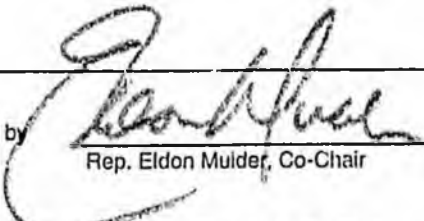
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1091 Designated Program Receipts						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

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

Rep. Gene Therriault, Co-Chair House Finance Committee

Phone 465-2647

Phone 465-4797

Date 4/16/99

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
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CHANGE IN REVENUES ()	0.0	0.0	0.0	0.0	0.0	0.0
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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 budget for these activities.

Prepared by Peter M Nakamura MD, MPH Phone 465-3090
 Division Public Health Date/Time #####
 Approved by Commissioner [Signature] 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**
- 



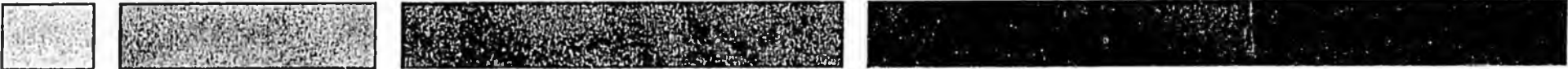
PUBLIC EDUCATION Effectiveness

- **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**
- 

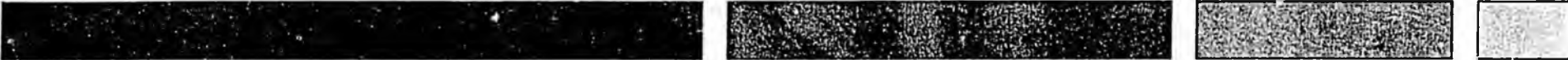


PROGRAM SUCCESS

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 tobacco 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:

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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
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CHANGE IN REVENUES ()	0.0	0.0	0.0	0.0	0.0	0.0
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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 [Signature] 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
- Reaching special populations such as youth, women, ethnic minorities, and low income individuals
- Technical support to provide updates 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 policy 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

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 budget for these activities.

Prepared by Peter M Nakamura MD, MPH Phone 465-3090
 Division Public Health Date/Time #####
 Approved by Commissioner [Signature] 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	\$7,004,000,060.00	\$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	\$24,375,539.93	\$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	\$105,799,566.63	\$117,959,711.74	\$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	\$37,997,749.17	\$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	\$154,339,422.44	\$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	\$205,977,356.58	\$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	\$72,962,200.02	\$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	\$68,390,333.34	\$59,349,136.35	\$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	\$61,578,817.49	\$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	\$301,314,952.34	\$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	\$54,590,425.53	\$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	\$42,239,835.47	\$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	\$46,612,020.04	\$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	\$1,050,945,263.21	\$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	\$717,989,369.09
Ohio	\$120,900,234.58	\$0.00	\$322,992,532.93	\$348,780,049.22	\$416,783,038.09	\$422,746,366.61	\$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
American Samoa	\$165,208.62	\$0.00	\$975,677.65	\$1,053,575.12	\$1,265,036.21	\$1,277,008.41	\$1,065,800.48	\$1,036,952.15	\$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 &
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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%.
- 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).

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.

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.

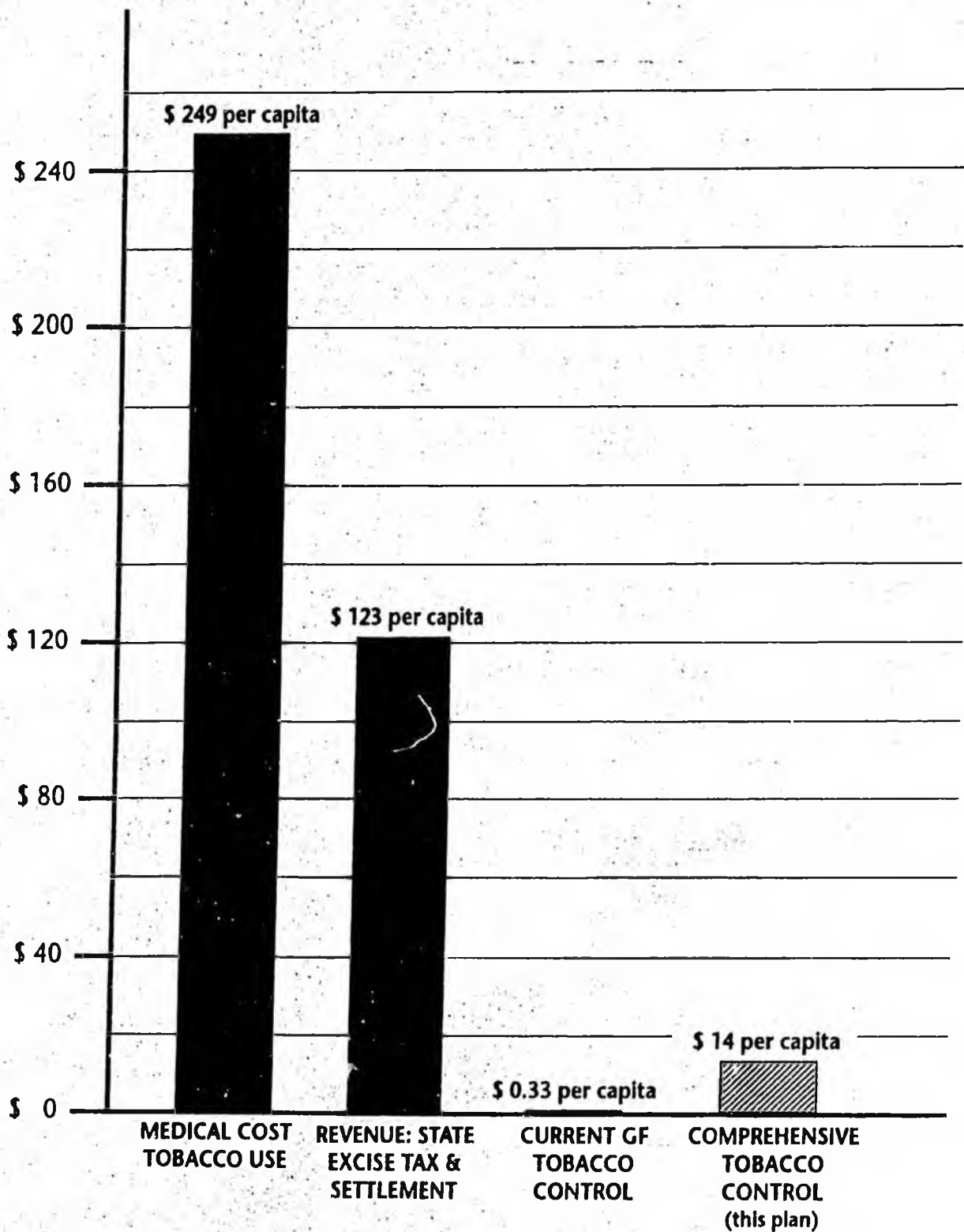
In November 1998, **Alaska joined a multi-state settlement with the tobacco industry** that is expected to provide \$669 million over the next 25 years. The ATCA plan for tobacco control could be funded with less than a third of the average annual payment from the settlement.

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.

ALASKA STATE LEGISLATURE

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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.