

## SPECIAL REPORT

## Tobacco Control in the Wake of the 1998 Master Settlement Agreement

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Tobacco takes an enormous toll on the health of the public as the cause of 440,000 deaths annually in the United States and 4.8 million deaths worldwide.<sup>1,2</sup> An estimated 8.6 million persons in the United States have serious smoking-related illness.<sup>3</sup> The World Health Organization projects that by the year 2030 the use of tobacco will kill 10 million persons annually — including 7 million in developing countries — which will make tobacco use the world's leading cause of preventable death.<sup>4</sup>

In 2001, the prevalence of smoking in the United States stood at 25.5 percent among men and 21.5 percent among women, down from the peaks of 57 percent among men in 1955 and 34 percent among women in 1965.<sup>5</sup> Rates of smoking have plateaued, however, since 1990.<sup>5</sup> The prevalence varies by state, ranging from 31 percent in Kentucky to 13 percent in Utah, and it is increasingly concentrated in populations that have relatively little education and low incomes.<sup>6</sup> Smoking rates are declining in all age groups, except among persons 18 to 24 years of age, among whom the prevalence rose from 23 percent in 1991 to 27 percent in 2000.<sup>7</sup>

Mental illness and smoking have been closely linked. For example, smoking rates have been reported to be over 80 percent among persons who have schizophrenia,<sup>8,9</sup> 50 to 60 percent among persons with depression,<sup>10</sup> 55 to 80 percent among those who have alcoholism,<sup>11,12</sup> and 50 to 66 percent among those who have substance-abuse problems.<sup>12,13</sup> One study estimated that smokers with coexisting psychiatric or substance-abuse disorders account for 44 percent of all cigarettes smoked in the United States, a percentage that reflects both the high prevalence of smoking in connection with these conditions and the fact that patients with these disorders are very heavy smokers.<sup>12</sup>

Worldwide, it is estimated that 47 percent of men but only 12 percent of women smoke.<sup>14</sup> As compared with smoking rates among men in other countries, in the United States the rate ranks in the lowest fifth, but it is higher than in Australia, Swe-

den, and many of the developing countries. By contrast, smoking rates among women in the United States are in the highest third for women worldwide. Globally, smoking rates among men are highest in Asia (e.g., 67 percent in China, 65 percent in Korea, and 53 percent in Japan), but the rates are also high in Russia (63 percent), Yugoslavia (52 percent), and Mexico (51 percent). In almost all nations, women are much less likely to smoke than men; among women, the smoking rate is a mere 4 percent in China and in Korea (and the rate is even lower in most Arab countries) but is about 33 percent in Argentina and Norway.<sup>4</sup>

In the relatively few countries that have anti-tobacco policies, government has provided the essential leadership; the exception is the United States, where grassroots action and litigation by citizens have generated most of the changes, including changes that were mediated by laws and regulations.<sup>15</sup> In the face of an aggressive tobacco industry that in 2001 spent \$11.2 billion on advertising and promotion in the United States alone,<sup>16</sup> effective control of the use of tobacco requires multiple policy strategies. Most of the promising approaches have not been fully implemented.<sup>17-20</sup>

In this Special Report I review the landmark \$209 billion Master Settlement Agreement (MSA) of 1998 between 46 states and the U.S. tobacco industry and, after a brief history of the MSA, assess its strengths and limitations as an instrument of tobacco control. Current U.S. tobacco-control policies at the federal, state, and local levels are summarized, with an emphasis on recent developments in the area of policy.

### THE 1998 MASTER SETTLEMENT AGREEMENT

The background and terms of the MSA between four major tobacco companies (Brown & Williamson, Lorillard, Philip Morris, and R.J. Reynolds) and the states' attorneys general illustrate the tension be-

tween the tobacco interests and those working to protect the public's health, as well as the conflicting pressures faced by those making tobacco-control policy in a time of budget deficits.

#### BACKGROUND

In 1994, which was the year in which David Kessler, then the commissioner of the Food and Drug Administration (FDA), asserted the agency's authority to regulate tobacco products, Michael Moore, the attorney general of Mississippi, and Hubert Humphrey III, the attorney general of Minnesota, sued the large tobacco companies to recover the costs to their states' Medicaid programs of treating tobacco-related illnesses. Every state in the country soon followed their lead. In 1996, a group of attorneys general, private attorneys, public health advocates, and tobacco-industry representatives began closed-door meetings to discuss a global settlement, as it was called, of all public and private litigation. At about the same time, Florida, Mississippi, Texas, and Minnesota settled with the tobacco companies on their own. In June 1997, details of the global settlement were announced. It required Congress to grant the tobacco industry limited immunity from new lawsuits for past actions and to enact certain public health provisions. Many advocates of tobacco control, most notably former surgeon general C. Everett Koop, Kessler, and Stanton Glantz of the University of California at San Francisco, criticized the global settlement as not going far enough.<sup>21</sup>

In April 1998, legislation to implement the global settlement — which was sponsored by Senator John McCain (R-Ariz.) and strengthened in response to criticisms by advocates of tobacco control — was voted out of the Senate Commerce Committee by a vote of 19 to 1 (with the one negative vote cast by then senator and now attorney general John Ashcroft).<sup>22</sup> However, the legislation never came to a vote in the full Senate, because its supporters failed by three votes to overcome a filibuster. The general settlement faltered owing to lukewarm support by the Clinton administration, ambivalence on the part of the public health community, and vigorous opposition from the tobacco industry, which spent \$50 million on a two-month campaign that was waged against the proposed legislation.<sup>21</sup>

Six months later, in November 1998, the attorneys general of the 46 states that had remained party to the suit did reach an agreement, called the MSA, with the four large tobacco companies to recover their Medicaid expenses and to penalize the com-

panies for their deceptive practices.<sup>23</sup> Because the MSA did not address federal regulation or federal programs, it did not require congressional approval.

#### TERMS OF THE AGREEMENT

In exchange for the states' abandonment of their suits, the tobacco companies awarded the states \$206 billion, to be paid over a period of 25 years and to be used by each state at its own discretion. After that time, payments will continue to be based on the volume of domestic cigarette sales by the four companies. Because state attorneys general do not have authority over state spending, the MSA was silent with regard to the ways in which the states would spend their funds. Indeed, with the exception of the creation by the MSA of the American Legacy Foundation for public education and other tobacco-control activities, which was to be supported for at least five years at a cost of approximately \$1.7 billion, no funds were earmarked by the settlement. Nevertheless, at the time of the settlement many states declared their intent to use the funds to help defray the costs to Medicaid of smoking-induced illnesses.<sup>24</sup> In addition, the MSA required the dissolution of the Tobacco Institute and other industry-promoting organizations, prohibited advertising targeted to young people (e.g., the use of cartoon characters such as "Joe Camel" and billboard advertising), and permitted wide dissemination of industry documents that had previously been kept secret.<sup>21,25-28</sup>

#### LIMITATIONS

Many tobacco-control elements that had been part of the general settlement were dropped from the MSA; these included the assignment of jurisdiction over tobacco to the FDA, strengthened warnings on packages of tobacco, tighter enforcement of rules banning the sale of tobacco to minors, and strong regulations in support of clean indoor air.<sup>26</sup> The MSA also included language that later hampered efforts aimed at tobacco control. For example, the bulk of the funding for the American Legacy Foundation expired after five years, because the funds depended on the four settling tobacco companies' maintaining a share of the domestic cigarette market of at least 99.05 percent.<sup>28</sup> In retrospect, that percentage was probably based on erroneous projections.

In the current climate of fiscal crises, the MSA funds have become an irresistible target from the perspective of state policymakers to help address

budget deficits and avert new taxes.<sup>26,29</sup> In many states, important tobacco-control activities — such as the landmark antismoking programs in Minnesota, Massachusetts, and Florida — are being dismantled. For example, in 2003 state antitobacco budgets were slashed by 99 percent in Florida and by 92 percent in Massachusetts. Even before the current fiscal crisis, less than 5 percent of state funds from the MSA was spent on tobacco control, and some states spent essentially nothing.<sup>25,29</sup> In fiscal year 2003, 47 percent of the MSA payments went into state budgets, which represents a sharp increase from 29 percent in the previous fiscal year and from 16 percent in the three preceding fiscal years.<sup>24</sup> Some might argue that because smoking-related Medicaid spending contributes to the states' budget deficits, the use of payments from the MSA fund to reduce the deficits is appropriate. Senator McCain, however, thinks otherwise and on November 12, 2003, held hearings on the use of the settlement funds. He opened the hearings by criticizing the National Governors Association and the National Council of State Legislators for failing to fulfill their promises.<sup>30</sup> According to McCain, at the time of the settlement there was general agreement that the money would be used “for tobacco education and treatment of smoking-related illnesses.”<sup>24</sup>

The states are increasingly mortgaging future payments from the MSA through bond issues and are thereby forfeiting future income for the sake of a smaller bird in the hand. To date, 20 states and the District of Columbia have either securitized their future MSA payments or announced their intention to do so<sup>31</sup> (Gallogly M, Campaign for Tobacco-Free Kids: personal communication). These transactions are known as “naked bonds,” because they transfer risk to the investors, with no state guarantee of payment. Recently, however, New York and California have sold tobacco bonds that were backed by state tax revenues. These states now have a financial incentive to keep the tobacco industry healthy, because if the companies forfeit their MSA payments, the financial obligations will revert to the states.<sup>32</sup> In an example of the states' protectiveness toward the tobacco industry, this year 37 state attorneys general supported the successful effort by Philip Morris to reduce a \$12 billion bond that had been ordered by an Illinois judge as part of a private suit that is currently under appeal. The states' concern was that if the tobacco companies were to be bankrupted as a result of high, court-mandated judgments, then the payments to the states under the MSA would cease.

Thus, the MSA has created perverse incentives for the states to keep the tobacco industry financially healthy.

#### STRENGTHS

Matt Myers, director of the Campaign for Tobacco-Free Kids and a major figure in the global-settlement discussions,<sup>21</sup> said in an interview that he credits the MSA with “the most significant increase in spending on tobacco prevention and cessation in history. These funds have forever changed the debate about the appropriate level of funding for tobacco control.” Certainly, even the paltry state expenditures broadened national tobacco-control efforts far beyond the earlier isolated examples of state spending for this purpose. The MSA funded the first important national countermarketing effort in 30 years (the American Legacy Foundation's “truth” campaign), which, along with increased tobacco taxes and other factors, has reduced the smoking rate among young people to a 27-year low.<sup>33</sup>

To pay for the antitobacco programs required under the MSA, tobacco companies have increased the price of cigarettes by 45 cents a pack. Given that the price elasticity of demand for tobacco in the United States is about  $-0.4$  — that is, for every 10 percent increase in price, there is a 4 percent decrease in demand — the increase may turn out to be the most important antitobacco benefit of the MSA, leading to both the prevention of smoking and smoking cessation.<sup>34</sup> High prices, however, may merely raise the age at which people start to smoke.<sup>35</sup>

The MSA has also made more tobacco-industry documents available. Researchers across the country are poring through these documents and publishing new revelations based on them about industry practices and tactics.<sup>36-38</sup>

#### WINNERS AND LOSERS

Of course, it would be easier to assess the effects of the MSA if it were possible to know what would have happened had the 46 settling states instead pursued separate litigation. How many suits would have come to trial, and with what results? How many states would have settled separately, and what settlements would have been reached? Although the answers to these questions will never be known, the consensus that has emerged is that the public lost a golden opportunity to improve its health. For example, the two state attorneys general most involved in both the global settlement and the MSA — Christine Gregoire of Washington and Michael Moore of

Mississippi — as well as tobacco-control experts such as economist Ken Warner of the University of Michigan, wish that the states had been more committed to tobacco control. In Moore's words, "I call it moral treason. The losers are the people in the states where the legislators have chosen to spend the money on budget deficits instead of long-term investment in health."<sup>24</sup>

Some saw the tobacco industry as the clear victor. For instance, Myers said in an interview that the settlement of "the most serious litigation threat the industry had ever faced, under terms that had little impact on how it conducts its business and at a cost it was able to pass on to its consumers," was a boon to the industry. Glantz, in an interview, took an even darker view: "Probably the tobacco industry will win in the long run, largely because of the securitization of the money putting pressure on states to keep tobacco consumption up to get their bonds paid off."

Glantz and Joseph Califano, Jr., the former secretary of Health, Education, and Welfare and now the president of the National Center for Addiction and Substance Abuse at Columbia University, are skeptical that Congress will ever pass global settlement-type legislation. "The MSA results from the failure of the U.S. Congress and most state legislatures to do their jobs," Califano said in an interview. "The result: the money is being spent to close budget deficits rather than to stop kids from smoking and help adults who are hooked. On balance, however, I believe we are far better off with the MSA than without it, because the alternative was nothing from a Congress that continues to pander to the tobacco interests."

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FEDERAL, STATE, AND LOCAL  
TOBACCO-CONTROL POLICIES

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For policymakers, there are three ways to reduce the harm caused by the use of tobacco: prevent initiation, encourage smoking cessation, and limit exposure to secondhand smoke. The universe of tobacco-control policies encompasses a wide variety of interventions that have had varying and often untested efficacy<sup>39</sup> (Table 1). As summarized in 2000 in the surgeon general's report on reducing tobacco use, "A hierarchy of effectiveness is difficult to construct."<sup>19</sup> That said, the evidence seems strongest for the effect of tobacco taxes<sup>34</sup> and legislation to promote clean indoor air.<sup>58</sup> In part, this reflects the ease of measuring these effects — taxes are either levied or not, smoking is either banned in offices,

restaurants, and bars or not — as compared with interventions such as countermarketing. And granted, there may be mitigating factors, such as the extent to which cigarette smuggling lowers selling prices or the extent to which laws to promote clean indoor air are enforced. But such factors pale beside the variable implementation of, for example, countermarketing efforts (the quality of the advertisements, the frequency with which they are aired, and the audiences to which they are targeted). And, in part, the evidence reflects the likelihood that raising taxes and imposing clean-indoor-air regulations may simply be more robust ways to reduce tobacco use than implementing programs to prevent people from starting to smoke or to promote smoking cessation.

A full discussion of all the tobacco-control policies listed in Table 1 is not possible here. Accordingly, I shall focus on four policies — tobacco taxes, clean-indoor-air requirements, smoking-cessation programs and services, and a convention on tobacco control sponsored by the World Health Organization.

**TAXATION**

The price elasticity of the demand for cigarettes is estimated to range from  $-0.3$  to  $-0.5$ , indicating a decrease in demand of 3 to 5 percent for every increase of 10 percent in price.<sup>19,34</sup> Thus, it would appear that one of the best ways to reduce smoking is to raise the cost of tobacco products through taxation, thereby both encouraging smoking cessation and discouraging the initiation of smoking. Between 1993 and 2002, the federal tax on cigarettes rose from 24 cents to 39 cents per pack. In 2002, the federal Interagency Subcommittee on Cessation, created by the secretary of Health and Human Services, Tommy G. Thompson, proposed raising the tax to \$2.39 per pack and using the resultant revenues to fund comprehensive smoking-cessation programs and services, a recommendation that was rejected by the administration of President George W. Bush.<sup>59</sup>

The rates of cigarette taxes vary greatly from state to state, ranging from a low of 2.5 cents per pack in Kentucky to a high of \$2.05 per pack in New Jersey, for an average of 66 cents per pack. Not surprisingly, tobacco taxes are generally lower in states that grow tobacco and in those that have more smokers.<sup>25</sup> Increases in state taxes either can be legislated or can result from ballot initiatives, such as the passage of Proposition 99 in California in 1988.<sup>60</sup> Recent bud-

**Table 1. Tobacco-Control Policies.\***

Area of Policy	Evidence and History
<b>Fiscal control</b>	
Federal, state, and local taxes on tobacco products†	Good evidence exists that the use of tobacco products is sensitive to price and that raising taxes discourages smoking.
Agricultural price supports	In 1982, Congress stabilized tobacco prices paid to farmers. Special additional payments can be authorized, as in 2000 and 2001. In 2003, the tobacco crop yield was the lowest since 1874; it has declined 40 percent since 1997. Federal legislation now being considered would phase out price stabilization and buy out tobacco farmers for \$13 billion. <sup>40-44</sup>
<b>Regulatory controls</b>	
Clean indoor air†	Good evidence exists that bans on smoking in workplaces, bars, and restaurants induce smokers to quit or cut back and protect nonsmokers.
Regulation and labeling of tobacco products	In 1994, the FDA sought federal regulation of the content of tobacco products but in 2000 this was rejected by the Supreme Court. Nicotine-replacement therapy is regulated by the FDA, but not nicotine-containing cigarettes. Warning labels on tobacco products, which are required by Congress, are weak as compared with those in Australia and Canada (Fig. 1). <sup>45-48</sup>
Advertising and promotion	In 1969, federal law banned radio and television advertising of tobacco products but simultaneously ended federal counteradvertising. Terms such as “low tar” and “light” remain unregulated. Some states (California, Massachusetts, and Florida) have conducted aggressive counteradvertising campaigns. <sup>49-52</sup>
Restrictions on sales to minors	Local enforcement varies. The provision in the Synar Amendment (1992) that calls for linking federal funds for substance-abuse treatment to enforcement of restrictions on sales to minors has not been enforced. Minors can easily purchase cigarettes over the Internet. There is no evidence that restrictions on sales to minors, even if enforced, would reduce smoking among young people. <sup>53-56</sup>
<b>Litigation</b>	
Federal suit against the six large tobacco companies	The lawsuit initiated by the Department of Justice in 1999 under the Clinton administration and brought forward by the present attorney general, John Ashcroft, seeks the payment of \$289 billion for reason of “fraudulent and deceptive marketing practices.” A trial date has been set for September 15, 2004, though many predict a settlement.
<b>Smoking-cessation programs†</b>	
Government health systems, quit lines	Although rates of smoking cessation are low, small increases in quitting owing to the use of treatments that have proved to be efficacious (counseling, nicotine-replacement therapy, and drugs such as bupropion) could have a substantial effect on the population of smokers. Because government pays for half of all health care expenditures through Medicare, Medicaid, VHA, Indian Health Services, the military, and programs for federal employees, government policies to promote smoking cessation are critical, as is government support of telephone quit lines. Coverage for smoking-cessation treatment is limited, although the VHA has set important diagnostic and treatment goals. There is no government support for establishing a national telephone quit line.
<b>Research on prevention and cessation</b>	
NIH and CDC	Many questions remain unanswered regarding the initiation of smoking, pathways to nicotine addiction, patterns of smoking, successful smoking-cessation treatments, and the coexistence of smoking with psychiatric and substance-abuse disorders. No one government agency “owns” smoking research. Expenditures for research are very small in relation to the size of the problem (the NIH spent less than 1 percent of its 2002 budget on such research‡). A few states, notably California, fund such research.
<b>Visible national leadership</b>	
Former surgeons general C. Everett Koop and David Satcher, former FDA commissioner David Kessler, and periodic reports on the prevalence of smoking	There is no visible antitobacco champion in the Bush administration. Periodic reports from the surgeon general, the CDC, and Healthy People highlight smoking-related issues in the United States. <sup>6,7,19,57</sup>
<b>International trade†</b>	
FCTC	The FCTC, sponsored by the World Health Organization and including many tobacco-control policies, was adopted by the World Health Assembly in May 2003. Whether the FCTC will be ratified and, if ratified, whether it will be successfully implemented will be influenced by the extent of support for it by the United States.

\* FDA denotes Food and Drug Administration, VHA Veterans Health Administration, NIH National Institutes of Health, CDC Centers for Disease Control and Prevention, and FCTC Framework Convention on Tobacco Control.

† See text for further details.

‡ Information is from Curtis ET, National Cancer Institute: personal communication.

get crises have goaded many states to raise tobacco taxes: 21 states raised this tax in 2002, and another 17 in 2003<sup>61</sup> (Gallogly M, National Center for Tobacco-Free Kids: personal communication). Municipal taxes provide a less powerful deterrent, because residents can easily purchase cigarettes nearby, where a lower tax is levied. Still, some cities impose a substantial tax; in New York City, the tax of \$1.50 raised the cost of a pack of cigarettes to more than \$7. The effect of tobacco taxes can be blunted by smuggling, which has become an international issue; countries vary greatly in the vigor with which they combat smuggling.<sup>62,63</sup>

#### CLEAN-INDOOR-AIR INITIATIVES

The creation of smoke-free public areas has been a major success of the antitobacco movement in the United States. A poll conducted in 1978 for the now-defunct Tobacco Institute showed that the nonsmokers'-rights movement "is the single greatest threat to the viability of the tobacco industry."<sup>64</sup> Mounting evidence of the dangers of secondhand smoke catalyzed action to create smoke-free areas and gave added support to the nonsmokers'-rights movement, which included the rights of workers in such industries as transportation and entertainment. Especially important was the decision of the Environmental Protection Agency in 1993 to classify secondhand smoke as a carcinogen.<sup>65</sup> The establishment of smoke-free areas has undermined the social acceptability of smoking, and concern about secondhand smoke has served to counter the tobacco industry's claim that smoking is a matter of individual choice.

Since 1973, federal legislation has required passenger airlines to establish separate sections in the airplanes for smoking and nonsmoking passengers on domestic flights, and it now bans smoking on all domestic flights, on all flights to and from the United States, and in most U.S. airports.<sup>15</sup> Five states — California, New York, Delaware, Connecticut, and Maine — have banned smoking in essentially all public places, including work sites, restaurants, and bars. (The Massachusetts legislature has passed similar legislation, and Governor Mitt Romney has announced his intention to sign the bill when it reaches his desk, in early 2004.) Another 32 states have imposed partial restrictions against smoking. More than 1600 counties and municipalities have passed laws to promote clean indoor air (Hallett C, Americans for Nonsmokers' Rights: personal communication). Increasingly, the states have become

battlefields for legislation to promote clean indoor air; 20 states have passed such legislation in order to preempt efforts by local communities to enact stricter clean air laws than those required by (usually relatively weak) state statutes (Hallett C, Americans for Nonsmokers' Rights: personal communication). Attempts by the Occupational Safety and Health Administration to control tobacco smoke in the workplace nationwide were defeated in 2001, after a lengthy campaign by the tobacco industry.<sup>66</sup>

#### SUPPORT OF SMOKING-CESSATION PROGRAMS

Of the 46 million smokers in the United States, 70 percent would like to quit, but each year less than 5 percent of these smokers are able to quit without assistance.<sup>67</sup> The odds of successfully quitting smoking can be doubled or even tripled if counseling, nicotine-replacement therapy, and treatment with drugs such as bupropion are used.<sup>68</sup> Because government pays half of all health expenditures in the United States, its payment policies greatly influence smoking-cessation practices. Medicaid covers some services and drug therapy in support of cessation in 34 states, but a 2001 study of 2 of these states showed that only a small percentage of patients and providers were aware of the coverage.<sup>69</sup> Medicare does not yet cover prescription drugs, nor does it provide a separate payment for outpatient smoking-cessation counseling. Coverage for smoking-cessation programs for federal employees is also spotty. Neither the military, despite its history of giving free cigarettes to the troops, nor the Indian Health Service, which provides health care to a population that smokes heavily, has developed a comprehensive program to identify and treat smokers.

The Veterans Health Administration (VHA) is poised to serve as a model health care system for smoking cessation. Among veterans, the smoking rate is higher than that in the general population, 33 percent as compared with 23 percent, and veterans are heavier smokers as well. Among veterans of the Vietnam war, the prevalence of smoking is 47 percent.<sup>70</sup> In 1997, the VHA mandated that veterans cared for in its system be asked about smoking and that smokers be counseled. Subsequently, the reported percentage of veterans asked about smoking rose from 49 percent in 1996 to 95 percent by 1999, and the reported percentage of smokers counseled increased from 33 percent in 1996 to 93 percent by 1999.<sup>70</sup> These rates are substantially higher than the rate among members of the private health plan that was reported to have the best performance (68 per-

cent of smokers received advice to quit), according to the National Committee for Quality Assurance.<sup>71</sup> Only 38 percent of all smokers covered by Medicare who were hospitalized as the result of an acute myocardial infarction in 2000 and 2001 received smoking-cessation counseling, as compared with 62 percent of similar patients in VHA facilities in 2000.<sup>72</sup> Fewer than half of the smokers receiving care from the VHA, however, received drug therapy to aid smoking cessation, reflecting variable local coverage policies.<sup>70</sup>

Telephone “quit lines,” which are available in 32 states and are available nationally through the American Cancer Society and the National Cancer Institute, greatly enhance the probability that smokers will quit, especially when the quit lines can provide a personal interaction with callers. So far, however, quit lines have been used by only a tiny minority of smokers.<sup>29,73</sup> Funding for quit lines depends on an unstable amalgam of state and voluntary sources, and as a result not all callers can be served.<sup>74</sup> Two states (Oregon and Michigan) closed their quit lines in 2003 because of budget constraints, and other states are poised to follow suit. A federally funded national quit line that would have a toll-free number and that would be linked with a media campaign to encourage smokers to call the number would be a major help, as would support for Web-based smoking-cessation services.

#### INTERNATIONAL TRADE POLICIES

Until recently, the United States opposed the Framework Convention on Tobacco Control (FCTC), which was sponsored by the World Health Organization in 2003 and which bans tobacco advertising to the extent permitted by each country's constitution, mandates aggressive warning labels (see, for example, Fig. 1), requires a list of tobacco ingredients on the packages, and imposes other controls that would end the use of the terms “light” and “mild” on cigarette packages and would crack down on tobacco smuggling.<sup>75</sup> On May 21, 2003, shortly after the United States dropped its opposition, the FCTC was adopted by a voice vote of the 192 members of the World Health Assembly.<sup>76</sup> For the FCTC to become a binding international treaty, it must be ratified by the legislative bodies of at least 40 nations. For ratification, a country's administration must sign the treaty and then refer the treaty to its legislature for approval. To date, 77 countries have signed the FCTC, but only Norway, Sri Lanka, Seychelles, Malta, and Fiji have ratified it. Whether the



**Figure 1.** Warnings on Cigarette Packages Produced in Australia (Panel A) and Canada (Panel B).

Bush administration will support the FCTC remains to be seen. The U.S. tobacco industry, which had worked to weaken the treaty, is expected to oppose ratification. Even if the FCTC is ratified, the vigor with which its provisions will be enforced will depend on the zeal of each country and will be greatly influenced by the attitudes and practice of the United States and its major tobacco-exporting companies.

#### CONCLUSIONS

There are four key ingredients of successful public health efforts — highly credible scientific evidence, passionate advocates, media campaigns, and law and regulation, usually at the federal level.<sup>77</sup> In the battle against the harmful effects of tobacco use, the scientific evidence came first, almost 50 years ago, and since then advocates of tobacco control have engaged in a four-decade battle against the U.S. tobacco industry.<sup>15</sup> Except for a two-year national media campaign against tobacco use in the late 1960s, there was little counteradvertising about tobacco until the mid-1990s, and initially it was run in only

a few states until the recent MSA-funded American Legacy Foundation's campaign. At the same time, government initiatives, particularly federal antitobacco efforts, have been relatively weak. In addition to the 440,000 Americans who die each year from smoking, another 8.6 million suffer from serious tobacco-induced illness.<sup>3</sup> Although U.S. smoking rates are slowly declining, progress toward that end would be faster if federal policymaking matched both the rigor of the scientific evidence against tobacco use and the resolve of antitobacco advocates.

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