

UP IN SMOKE:

NEW YORK REAPS BILLIONS IN REVENUE
FROM TOBACCO WHILE SHORT CHANGING
ANTI-SMOKING PROGRAMS

ENDORSED BY:

- AMERICAN CANCER SOCIETY
- AMERICAN HEART ASSOCIATION
- AMERICAN LUNG ASSOCIATION IN NEW YORK
- CAMPAIGN FOR TOBACCO-FREE KIDS
- LEAGUE OF WOMEN VOTERS/N.Y.S.
- NEW YORK PUBLIC INTEREST RESEARCH GROUP

September 2011

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Written by Russ Sciandra and Blair Horner of the American Cancer Society, Eastern Division.

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UP IN SMOKE: EXECUTIVE SUMMARY

Since 1999, New York has raised billions of dollars in tobacco revenues, largely resulting from several significant increases in the state's tax on tobacco products. These hikes in taxes act as an important deterrent to smoking by adults and children. However, those benefits are severely undercut because the state uses little of those revenues to fund smoking cessation and anti-tobacco public education programs.

This report examines the inadequacy of New York's anti-smoking efforts in light of the significant resources available. We find that only a tiny fraction of revenue the state derives from tobacco use is being used for tobacco control efforts, and that the state is spending far less than recommended by the federal government. As a result, the potential public health benefits and savings that would be realized through robust funding of tobacco control programs are going "Up In Smoke."

► FINDINGS:

- New York has raised \$10.5 billion in tobacco revenues over the past six years, yet less than four percent has been spent on tobacco control programs. To be clear, only about four pennies of every dollar raised by tobacco taxes goes to help people quit smoking. This inadequate spending stands in stark contrast to previous promises made by public officials to invest these state dollars in tobacco control.
- In the current fiscal year, New York will spend on tobacco control only 16 percent of the amount recommended by the Centers for Disease Control and Prevention. *In addition, over the past three years funding for the tobacco control program has been cut in half.*
- Tobacco use takes a terrible toll on New York. In 2009, 25,400 lives were prematurely lost due to tobacco use. In addition, the state lost an estimated \$8.17 billion in health care costs and \$2.7 billion in Medicaid costs as a result of tobacco use.
- Tobacco control programs have been proven to reduce youth smoking and help current smokers to quit.
- When more adequately funded, the New York tobacco control programs achieved successes in the effort to curb tobacco use, especially in preventing young people from becoming smokers. Teenage and adult tobacco use rates have fallen faster in New York than in the U.S. as a whole. In 2010, 12.6 percent of teenagers, and 15.5 percent of adults, were smokers.
- Limited funding prevents the Tobacco Use Prevention and Control Program from reaching the most vulnerable populations with the highest rates of smoking. Increasingly, the burden of tobacco taxes falls most heavily on those least able to pay.

► RECOMMENDATIONS:

- New York should spend a dime in every dollar of revenue from tobacco sales on tobacco control. New York must fulfill its promises to use tobacco revenues for programs to help smokers to quit and to keep children from smoking. We recommend **incrementally increasing Tobacco Program Funding to the CDC-recommended level of \$254 million per year**. The program's annual budget should be increased to \$100 million in 2012-13 and then, as its capacity grows, increased by \$50 million every year until it reaches the target appropriation.
- **Target more resources to adult cessation.** Achieving near-term reductions in tobacco use rates, and the incidence of tobacco-caused disease, will best be accomplished by encouraging adult smokers to quit and providing resources to help them succeed. Only by motivating smokers to attempt to quit smoking and providing the pressure, resources, and support to make those attempts successful will near-term smoking rates decline, disease rates decline, premature deaths decline, and economic savings accrue. Most smokers want to quit, and encouraging and assisting adult cessation is a cost-effective tobacco control strategy.
- **Increase community level interventions, especially in disadvantaged urban neighborhoods and rural areas.** To change social norms a program must be well integrated into a community. Program personnel must understand and, preferably, live in, the communities they work in. At least one-third of any budget increase should be directed to increasing the level of community activity.
- **Increase funding for anti-smoking media messages.** As quickly as possible, the TCP should increase its media budget and target messages to those, such as the poor and non-English speakers, that the program has not been reaching.
- **Develop and implement strategies for reaching those with mental illness or addictive disorders:** People with mental illness smoke at a rate almost twice that of the general public. Increasingly, tobacco use is concentrated in this population, and if the problem is not addressed now, the burden of tobacco use will increasingly fall on those least able to absorb it.

UP IN SMOKE: IN SIX YEARS, TOBACCO HAS GENERATED OVER \$10 BILLION IN REVENUES FOR NEW YORK

New York State generates a staggering amount of revenue from tobacco each year. These tobacco revenues come from two main sources: (1) the state's tobacco taxes; and (2) monies that result from litigation commenced by New York against tobacco product manufacturers.

► TOBACCO TAXES

New York's cigarette excise tax is \$4.35 per pack. In the fiscal year that ended March 31, 2011, New York State collected \$1.351 billion in taxes on cigarettes and other tobacco products.¹ Moreover, New York includes the excise tax in the base when calculating the sales tax on cigarettes, and tax revenue from the assessment on the excise tax portion of the cost alone was approximately \$54 million. The City of New York imposes an additional tax of \$1.50 per pack on sales there.

► THE MASTER SETTLEMENT AGREEMENT

In the same fiscal year, New York State received \$391.3 million in Master Settlement Agreement (MSA) payments from tobacco product manufacturers,² bringing total annual revenue from tobacco to **\$1.796 billion**. It is important to note that most, if not all, of this cost is borne by the consumers of tobacco products in the form of higher retail prices.

The revenue generated from New York's litigation arises from the MSA, an agreement between the nation's largest cigarette companies and 46 states. The MSA requires those cigarette companies to, among other things, annually pay billions of dollars to the states as compensation for the health costs to their Medicaid programs resulting from tobacco use.

After the MSA was signed in November 1998, many governors, state attorneys general, and other high-ranking state officials expressed strong support for investing substantial portions of the tobacco settlement payments in new efforts to prevent and reduce tobacco use in their states.

For example, Governor Thomas Carper, Chairman of the National Governors Association and Utah Governor Michael Leavitt, Vice Chair, wrote in letter to U.S. Senate Minority Leader Daschle, March 5, 1998:

"The nation's Governors are committed to spending a significant portion of the tobacco settlement funds on smoking cessation programs, health care, education, and programs benefiting children."

Announcing the settlement, then-New York Attorney General Dennis Vacco released a statement on November 16, 1998 which stated:

"As a result, millions of children who are not yet smokers will be spared horrific diseases and suffering, **and millions of current smokers will get a real chance to quit and reclaim their good health.**"³

However, it was not just promises made by high-ranking public officials in press releases. The pledge to use the MSA revenues to curb tobacco use is found in the agreement itself. Most notably, the MSA begins with a series of "Whereas" clauses, including the following:

- **WHEREAS**, the Settling States that have commenced litigation have sought to obtain equitable relief and damages under state laws, including consumer protection and/or antitrust laws, in order to further the Settling States' policies regarding public health, including policies adopted to achieve a significant reduction in smoking by Youth ...
- **WHEREAS**, the Settling States and the Participating Manufacturers are committed to reducing underage tobacco use by discouraging such use and by preventing Youth access to Tobacco Products;

¹ However, taxes on other tobacco products, while high, are not at equal rates to the cigarette tax, making those products more accessible to youth.

² New York State shares its MSA payments with each county and the City of New York. The state retains 51.2% (in 2010, \$391.3 million) of the annual payments.

³ New York State Office of the Attorney General, News Release, "Vacco: \$200 Billion Tobacco Plan to Protect Health of Kids," November 16, 1998.

- ▶ **WHEREAS**, the undersigned Settling State officials believe that entry into this Agreement and uniform consent decrees with the tobacco industry is necessary in order to further the Settling States' policies designed to reduce Youth smoking, to promote the public health and to secure monetary payments to the Settling States; and
- ▶ **WHEREAS**, the Settling States and the Participating Manufacturers ... have agreed to settle their respective lawsuits and potential claims pursuant to terms which will achieve for the Settling States and their citizens significant funding for the advancement of public health, the implementation of important tobacco-related public health measures, including the enforcement of the mandates and restrictions related to such measures, as well as funding for a national foundation dedicated to significantly reducing the use of Tobacco Products by Youth.⁴

These excerpts clearly indicate that the states are supposed to use their MSA payments to advance public health and support tobacco-prevention efforts. Indeed, the last clause explicitly says just that, and also very clearly declares that the states are expected to use their MSA funding for tobacco-prevention and other public health efforts.

However, over 12 years later, the promises to use the settlement monies for tobacco prevention has eroded – or been ignored.

As seen in the chart below, New York State has raised \$10.5 billion in tobacco revenues over the past six years. Yet during that time, spending to prevent kids from smoking and to help smokers quit has plummeted.

The money is amply available; it is the commitment that is missing.

New York Has Raised Billions from Tobacco and Spent Little On Tobacco Control				
FISCAL YEAR	AMOUNT SPENT ON TOBACCO CONTROL⁵ (Millions)	TOTAL REVENUE FROM TOBACCO⁶ (Billions)	REVENUE FROM TOBACCO TAXES⁷ (Millions)	REVENUE FROM TOBACCO SETTLEMENT⁸ (Millions)
FY 2007	\$85.5	\$1.4 b	\$980.6	\$396.7
FY 2008	\$85.5	\$1.4 b	\$1 b	\$427.3
FY 2009	\$80.4	\$1.9 b	\$1.4 b	\$469.4
FY 2010	\$55.2	\$1.8 b	\$1.4 b	\$391.3
FY 2011 ⁹	\$58.4	\$1.9 b	\$1.5 b	\$370.4
FY 2012 ¹⁰	\$41.4	\$2.1 b (est)	\$1.7 b	\$355 (est)
TOTAL	\$406.4	\$10.5 b	\$7.98 b	\$2.4 b

The MSA also had an effect on the *price* of cigarettes. Reports at that time cited statements by the largest cigarette companies that they estimated per pack price increases of 45 cents – the largest price increase up to that date.¹¹ Coupled with soon-to-be enacted tobacco tax hikes, the cost of smoking was about to go up.

These price increases have impacted tobacco consumption. A paper,¹² examined 523 published estimates of cigarette price elasticity from the academic literature. It found a median adult short-run price elasticity of 0.40 (long-run elasticity was 0.44). This means that for every 10 percent increase in price, there is a 4 percent decrease in consumption. About half the decreased consumption is due to adult smokers quitting, and half is due to smokers who continue smoking at a reduced rate. In the years since the MSA-caused price increase took effect (and most states raised their cigarette excise tax, many more than once), tobacco consumption throughout the U.S. has declined.

⁴ Master Settlement Agreement, November 23, 1998, See: <http://www.naag.org/backpages/naag/tobacco/msa>.

⁵ Campaign for Tobacco Free Kids, See: <http://www.tobaccofreekids.org/research/factsheets/pdf/0209.pdf>.

⁶ Campaign for Tobacco Free Kids, See: <http://www.tobaccofreekids.org/research/factsheets/pdf/0220.pdf>.

⁷ Calculations by authors, subtracted settlement amounts from total tobacco revenues.

⁸ For settlement payments from FY 2007-2010, See: <http://www.tobaccofreekids.org/research/factsheets/pdf/0365.pdf>

⁹ For FY 2011, Source: <http://www.tobaccofreekids.org/research/factsheets/pdf/0219.pdf>.

¹⁰ For 2012, NYS Enacted Budget Financial Plan for Fiscal Year 2012. New York State Division of the Budget. May, 2011.

¹¹ Meier, B. "Cigarette Maker Raises Price 45 Cents A Pack", *The New York Times*, October 24, 1998, p. A 20.

¹² Gallet, C.A., List, J. A., "Cigarette Demand: A Meta-Analysis of Elasticities", *Journal of Health Economics*, V. 12, October 2003, p.821-835.

UP IN SMOKE: THE BURDEN OF TOBACCO EXPOSURE IN NEW YORK, ESTIMATED AT \$8 BILLION ANNUALLY

Tobacco kills more than 25,000 New Yorkers every year, more than any other cause.¹³ Nearly one in every five deaths is attributable to tobacco use, and more than half a million New Yorkers currently suffer from a chronic illness such as cancer, cardiovascular disease or chronic obstructive pulmonary disease that was caused by smoking.¹⁴ Unless current trends are changed, 389,000 children under 18 and now living in New York will eventually die prematurely from diseases caused by tobacco – diseases that can be avoided.¹⁵

Tobacco is a source of considerable revenue to New York State and local governments. Unfortunately, it is a source of even greater costs.

The Centers for Disease Control & Prevention (CDC) estimates New Yorkers spend **\$8.17 billion** annually on direct medical care to treat smoking caused illness. These costs are concentrated at the two ends of the life span: nursing home expenses incurred by patients with tobacco-caused lung and cardiovascular diseases, and low birth weight babies born to mothers who smoke during pregnancy, and include \$5.4 billion on tobacco-related Medicaid costs.¹⁶ The state and county governments together pay half of Medicaid costs, with the federal government providing the other half. New York taxpayers thus pay **\$2.7 billion** to care for Medicaid patients with tobacco-caused illnesses.

In 2010, state and local government revenue from tobacco excise taxes, sales taxes on tobacco products and the MSA totaled approximately \$1.6 billion. Thus, there is a gap of more than one billion dollars, or \$154 per household per year, between tobacco-caused state and local expenditures (for Medicaid alone) and tobacco-generated state and local revenues.

Tobacco imposes additional costs of more than \$6 billion in lost productivity due to acute and chronic illness, with the consequent reduced economic activity leading to lost tax revenue.

The Toll of Tobacco Use in New York State, 2009¹⁷

High school students who smoke	14.8% (161,700)
Male high school students who use smokeless or spit tobacco	12.2% (females use much lower)
Kids (under 18) who become new daily smokers each year	24,100
Kids exposed to secondhand smoke at home	1,120,000
Packs of cigarettes bought or smoked by kids each year	38 million
Adults in New York who smoke	18% (2,721,100)
Adults who die each year from their own smoking	25,400
Kids now under 18 and alive in New York who will ultimately die prematurely from smoking	389,000
Adult nonsmokers who die each year from exposure to secondhand smoke	2,770
Annual health care costs in New York directly caused by smoking	\$8.17 billion
Portion covered by the state Medicaid program	\$5.4 billion
Residents' state & federal tax burden from smoking-caused government expenditures	\$889 per household
Smoking-caused productivity losses in New York	\$6.05 billion

¹³ Centers for Disease Control and Prevention, *Best Practices for Comprehensive Tobacco Control Programs - 2007*, October 2007, p. 90 (NY), p. 88 (NJ). See: http://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2007/BestPractices_Complete.pdf.

¹⁴ Hyland A, Vena C, Bauer, J et al. "Cigarette-attributable Morbidity in the United States". Presented at The Society for Research on Nicotine and Tobacco Meeting, Savannah, Georgia, February, 2002.

¹⁵ Centers for Disease Control and Prevention, *State Data Highlights Report*, 2006. http://www.cdc.gov/tobacco/data_statistics/state_data/data_highlights/2006/pdfs/dataHighlights06rev.pdf.

¹⁶ Centers for Disease Control and Prevention, *State Data Highlights Report*, 2006.

¹⁷ Campaign for Tobacco Free Kids, See: http://www.tobaccofreekids.org/facts_issues/toll_us/new_york

The most recent in-depth analysis of smoking behavior in New York¹⁸ shows significant variation in smoking prevalence, daily consumption and smoking cessation among various demographic groups. Smoking prevalence peaks in the early 20's and steadily declines as people grow older. Men are still slightly more likely than women to be regular smokers, and have higher average consumption. Except for Asians, who smoke at half the rate of the general population, there are not large differences in the prevalence of smoking among New York's major ethnic groups.¹⁹

Analysis of the state's smoking rates find a strong socioeconomic gradient in tobacco use. Smoking prevalence is highest among the poor: persons with family incomes under \$20,000 a year constitute more than one-quarter of the state's smokers. Thirteen percent of smokers are on Medicaid and one quarter has no health insurance.²⁰ People living in rural areas are significantly more likely to smoke than those living in city centers, with smoking prevalence highest among under educated, low-income rural individuals.²¹

Individuals with mental health and/or substance abuse problems have been reported to smoke at significantly elevated rates, an observation borne out in surveys of New Yorkers. Among those reporting mental health problems (an imperfect measure of the true picture), more than 36 percent smoke, more than twice the rate of those not reporting problems. And those with self-reported mental health problems smoke 20 percent more cigarettes per day.²²

The implications of these differences are staggering. There is a 25 year mortality gap between people with behavioral health conditions and the general public.²³ More alcoholics die of tobacco-caused disease than alcohol-related problems.²⁴ Many mental health clients are poor, and cigarettes consume a large proportion of their discretionary spending. Smokers with behavioral health problems respond to the same smoking cessation treatments as the general population and, like the general population, most want to quit.²⁵

¹⁸ Engelen, M, Farrelly, M, *Who's Smoking in New York?*, New York State Department of Health, October 2007.

¹⁹ *Ibid*, p 16.

²⁰ *Ibid*, p. 15.

²¹ *Ibid*, p. v.

²² *Ibid*, pp 32 - 33.

²³ Colton, C., Mandersheid, R. "Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states." *Preventing Chronic Disease: Public Health Research, Practice and Policy*, 3. 2006.

²⁴ Hurt, R.D., et. al. "Mortality following inpatient addictions treatment." *Journal of the American Medical Association*, 274(14), 1097 -1103.

²⁵ Schroeder, S. A., Morris, C. D. "Confronting a neglected epidemic: tobacco cessation for persons with mental illness and substance abuse problems." *Annual Review of Public Health*, 31: 16.1 – 16.18. 2008.

UP IN SMOKE: EXPERT RECOMMENDATIONS FOR TOBACCO CONTROL SPENDING IN NEW YORK

In the past three decades, a substantial body of scientific evidence has been developed about how to best reduce tobacco use in the population. Indeed, more is understood about how to change human tobacco use behavior than is known about impacting most behavior-based health problems.

► TOBACCO CONTROL WORKS

Since 1990, several states, including New York, have for at least a period of time funded comprehensive programs that implement this body of knowledge in a coordinated way. In a 2007 publication, Ending the Tobacco Problem: A Blueprint for the Nation, the prestigious Institute of Medicine of the National Academy of Science concluded, "The evidence ... shows that comprehensive state programs have achieved substantial reductions in the rates of tobacco use ... this is particularly true ... when states aggressively funded and implemented their tobacco control programs."²⁶

The best way for a state to substantially reduce tobacco use and its attendant harms and costs is to establish an adequately funded comprehensive tobacco prevention program employing a variety of effective approaches, including smoke-free laws and periodic tobacco tax increases. Nothing else will compete as successfully against the addictive power of nicotine and the tobacco industry's aggressive marketing tactics.

A 2006 study published in the *American Journal of Health Promotion* provides evidence of the effectiveness of comprehensive tobacco control programs and tobacco control policies. The study's findings suggest that well-funded tobacco control programs combined with strong tobacco control policies increase cessation rates. Quit rates in communities that experienced both policy and programmatic interventions were higher than quit rates in communities that had only experienced policy interventions (excise tax increases or secondhand smoke regulations). This finding supports the claim that state-based tobacco control programs can accelerate adult cessation rates in the population and have an effect beyond that predicted by tobacco-control policies alone.²⁷

By itself, a significant increase to a state's excise tax on cigarettes will directly reduce smoking, especially among youth. But combining tobacco tax increases with a comprehensive statewide tobacco prevention campaign will accelerate, expand, and sustain the tobacco use declines in the state, thereby saving more lives and saving more money, and saving both sooner.

The rise in smokers' calls to Quitlines following state cigarette tax increases shows how important it is to have cessation resources available to smokers who wish to quit in response to cigarette tax increases. For example, after the most recent cigarette tax increases in Michigan (from \$1.25 to \$2.00 per pack) and Montana (\$0.70 to \$1.70), smoker calls to the state smoking Quitlines skyrocketed. In the six months after the tax increase, the Michigan Quitline received 3,100 calls, compared to only 550 in the previous six months; and in Montana more than 2,000 people called in the first 20 days after the tax increase, compared to only 380 calls per month previously.²⁸ Likewise, in Texas and Iowa, the numbers of calls to their state Quitlines have been much higher after each increased their cigarette taxes by \$1.00 in 2007, compared to the previous year.²⁹ Probably the most dramatic example is from Wisconsin, which received a record-breaking 20,000 calls to its state Quitline in the first *two months* after its \$1.00 cigarette tax increase went into effect on January 1, 2008 – compared to typically 9,000 calls per year prior to the tax increase.³⁰

Experts regard the volume of Quitline calls as only one indicator of cessation activity in the population at large. For every would-be quitter that calls the Quitline, there are several that make the attempt without the Quitline's assistance, and an increase in the number of Quitline calls should be interpreted as a much larger increase in the total number of smokers attempting to quit.

²⁶ Institute of Medicine of the National Academies, Ending the Tobacco Problem: A Blueprint for the Nation. Washington, D.C., The National Academies Press, p. 171.

²⁷ Hyland, A, et al., "State and Community Tobacco-Control Programs and Smoking - Cessation Rates Among Adult Smokers: What Can We Learn From the COMMIT Intervention Cohort?" *American Journal of Health Promotion* 20(4):272, April/March 2006.

²⁸ "Tobacco Tax Pushing Smokers to Quit, State Says," *WMMT News*, January 26, 2005; Ecke, R, "Phone Lines Smokin' With Quit Line Calls," *Great Falls Tribune*, January 26, 2005.

²⁹ Souza, M, "Thank you for Smoking," *Longview-News Journal*, April 22, 2007; "Calls to Quitline Iowa double after cigarette tax raised," *AP*, March 22, 2007.

³⁰ Wisconsin Tobacco Quitline, "Calls to Wisconsin Tobacco Quit Line Break All Records," Press Release, February 28, 2008.

The evidence is clear – when states increase their tobacco tax, quit attempts and the demand for assistance in quitting increase, and in many cases, increase dramatically. New York’s high excise tax has clearly impacted consumption, but increased wide-spread tax evasion, principally through Native American reservation sales, has at least partially undercut its public health benefit.³¹ The State’s recent success in the courts holds promise of a significant reduction in tax avoidance and an increase in the effective price of cigarettes. But there is also evidence that, independent of policy changes such as higher tobacco taxes, comprehensive programs are effective in reducing smoking rates.

▶ **CALIFORNIA.** A study in the *American Journal of Public Health* found that both the 25-cent cigarette tax increase and the state’s anti-smoking media campaign were statistically significant in reducing cigarette sales in California from 1990 to 1992. Results show that the tax increase contributed to an 819 million pack decline in cigarette sales, and the anti-smoking media campaign reduced cigarette sales by 232 million packs.³²

▶ **MASSACHUSETTS.** A study of smoking declines in Massachusetts found that more than 55% of the declines in state cigarette sales from 1992 and 1998 were due to the efforts of the Massachusetts Tobacco Control Program. The study noted that, while other factors, such as rising cigarette prices, contributed to the declines in smoking, “the single most important factor appears to be the Tobacco Control Program.”³³

▶ **OREGON** increased its state cigarette tax by 30 cents per pack in 1997 to establish the state’s new Tobacco Prevention and Education Program. From 1996 to 1998, per capita cigarette consumption declined by 11.3 percent. Discounting other factors, the U.S. Centers for Disease Control and Prevention (CDC) estimated that slightly more than half of the decrease was prompted by the tax increase, with most of the remainder likely caused by the state’s comprehensive prevention program.³⁴

▶ **INCREASED FUNDING EQUALS DECREASED TOBACCO USE**

Tobacco use prevention and control is not cheap. Tobacco use still afflicts more than two and one-half million New Yorkers, and interventions must reach large numbers of people to have a significant public health impact. Where a public health benefit has been realized, it has been due to the synergistic impact of multiple, well-funded interventions and public policies, applied over a period of several years. Experts have stressed the importance of a comprehensive and balanced intervention that adequately addresses all the vital elements of a tobacco control program.

A recent study published in the *American Journal of Public Health* examined state tobacco prevention and cessation funding levels from 1995 to 2003 and found that the more states spent on these programs, the larger the declines they achieved in adult smoking, even when controlling for other factors such as increased tobacco prices. The researchers also calculated that if every state had funded their programs at the levels recommended by the CDC during that period, there would have been between 2.2 million and 7.1 million fewer smokers in the United States by 2003.³⁵ The Campaign for Tobacco-Free Kids estimates that such smoking declines would have saved between 700,000 and 2.2 million lives as well as between \$20 billion and \$67 billion in health care costs.

The study described above adds to earlier research, using similar methods, which demonstrated the same type of relationship between program spending and youth smoking declines. A 2005 study concluded that if every state had spent the *minimum amount* recommended by the CDC for tobacco prevention, youth smoking rates nationally would have been between three and 14 percent lower during the study period, from 1991 to 2000. Further, if every state funded tobacco prevention at CDC minimum levels, states would prevent nearly two million kids alive today from becoming smokers, save more than 600,000 of them from premature, smoking-caused deaths, and save \$23.4 billion in long-term, smoking-related health care costs.³⁶

³¹ Loomis, B., Kim A., Nguyen, Q., Farrelly, M., *Implications of the June 2008 \$1.25 Cigarette Tax Increase*, New York State Department of Health, November, 2010.

³² Hu, T-W, et al., “Reducing Cigarette Consumption in California: Tobacco Taxes vs. an Anti-smoking Media Campaign,” *American Journal of Public Health*, 85:1218-1222, 1995.

³³ Farrelly, M, letter to the editor, *Boston Globe*, December 9, 2002 [Farrelly is a tobacco researcher at the Research Triangle Institute in Research Triangle Park, North Carolina].

³⁴ Centers for Disease Control and Prevention, “Decline in cigarette consumption following implementation of a comprehensive tobacco prevention and education program – Oregon 1996 -1998,” *MMWR* 48(07):140-03, February 26, 1999, <http://www.cdc.gov/mmwr/preview/mmwrhtml/00056574.htm>.

³⁵ Farrelly, MC, et al., “The Impact of Tobacco Control Programs on Adult Smoking,” *American Journal of Public Health* 98:304-309, February 2008.

³⁶ Tauras, JA, et al., “State Tobacco Control Spending and Youth Smoking,” *American Journal of Public Health* 95:338-344, February 2005.

A study published in the *Journal of Health Economics* found that states with the best funded and most sustained tobacco prevention programs during the 1990s – Arizona, California, Massachusetts and Oregon – reduced cigarette sales more than twice as much as the country as a whole (43% compared to 20%). This new study, the first to compare cigarette sales data from all the states and to isolate the impact of tobacco control program expenditures from other factors that affect cigarette sales, demonstrates a dose-response relationship between spending on tobacco prevention and declines in smoking. In essence, the more states spend on tobacco prevention, the greater the reductions in smoking, and the longer states invest in such programs, the larger the impact. The study concludes that cigarette sales would have declined by 18% instead of nine percent between 1994 and 2000 had all states fully funded tobacco prevention programs.³⁷

► PROGRESS STALLS WHEN FUNDING IS REDUCED

A 1998 study in the *Journal of the American Medical Society* found that California's progress in reducing adult and youth smoking stalled when the state cut its tobacco prevention funding in the mid 1990s. Similarly, the impressive initial declines in youth smoking after Florida began its own state tobacco control program completely stopped among some age groups and even reversed among others after subsequent funding cuts.³⁸

► TOBACCO CONTROL IS A GOOD INVESTMENT

Given the findings regarding the effectiveness of tobacco control program, it is not surprising that other studies have found that, when adequately funded, the Massachusetts tobacco prevention program was reducing smoking-caused healthcare costs in the state by \$2 for every single dollar spent on the program, and that the longer-running California program was saving more than \$3.50 for every dollar the state spent on the program.³⁹

Research in California shows that the state's tobacco prevention program, by reducing the number of low-birthweight babies, saved the state more than \$100 million in healthcare costs in its first seven years.⁴⁰ In New York, the cost of more than half of all births and any complications are paid by Medicaid.

A more recent study of California's tobacco prevention program found that for every dollar the state spent on its tobacco control program from 1989 to 2004, the state received tens of dollars in savings in the form of sharp reductions to total healthcare costs in the state.⁴¹ This study confirms that the cost-saving benefits from sustained state investments in effective tobacco control programs quickly grow over time to dwarf the state expenditures; producing massive gains for the state not only in terms of both improved public health and increased worker productivity but in reduced government, business, and household costs.

► COMPONENTS OF A MODEL TOBACCO CONTROL PROGRAM

Programs that successfully encourage smokers to quit can produce a more immediate and probably larger public health benefit than any other component of a comprehensive tobacco control program. Recommendations that define a comprehensive statewide tobacco control program are provided in the CDC's *Best Practices for Comprehensive Tobacco Control Programs*.⁴²

A comprehensive tobacco control program has three main components: (1) mobilizing communities to change social norms and public policies so that they discourage tobacco use by adults and children, including promoting smoking restrictions to protect nonsmokers from exposure to second hand smoke; (2) using media and counter-marketing to educate both adults and children about tobacco issues, expose tobacco industry propaganda, and deglamorize tobacco use; and (3) treating adult smokers' nicotine addiction. These components are supported and strengthened by surveillance and evaluation activities and by training and program administrative support.

³⁷ Farrelly, MC, et al., "The impact of tobacco control program expenditures on aggregate cigarette sales: 1981-2000," *Journal of Health Economics* 22:843-859, 2003.

³⁸ Pierce, JP, et al., "Has the California Tobacco Control Program Reduced Smoking?," *Journal of the American Medical Association (JAMA)* 280(10):893-899, September 9, 1998; Florida Department of Health, *2001 Florida Youth Tobacco Survey*, Volume 4, Report 1; October 22, 2001, www.doh.state.fl.us/disease_ctrl/epi/FYTS.

³⁹ Harris, J., "Status Report on the Massachusetts Tobacco Control Campaign, with a Preliminary Calculation of the Impact of the Campaign on Total Health Care Spending in Massachusetts," 2000; Tobacco Control Section, California Department of Health Services, *California Tobacco Control Update*, April 2000, www.dhs.ca.gov/tobacco.

⁴⁰ Lightwood, JM, et al., "Short-term Health and Economic Benefits of Smoking Cessation: Low Birthweight," *Pediatrics* 104(6): 1312-1320, December 1999.

⁴¹ Lightwood, JM et al., "Effect of the California Tobacco Control Program on Personal Health Care Expenditures," *PLOS Medicine* 5(8): 1214-22, August 2008, <http://medicine.plosjournals.org/perlserv/?request=getdocument&doi=10.1371%2Fjournal.pmed.0050178>.

⁴² Centers for Disease Control and Prevention, *Best Practices for Comprehensive Tobacco Control Programs*, Atlanta, GA: U.S. Department of Health and Human Services (HHS), October 2007, http://www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/best_practices

In a comprehensive program, these individual program elements (and additional effective interventions which may be identified) work together to prevent and reduce tobacco use. Reducing the broad social acceptability of tobacco use necessitates changing many facets of the social environment in which tobacco products are used and marketed. This scale of societal change is a complex process that must be addressed by multiple program elements working together.

Inadequately supported interventions have been shown to have little or no effect. Tobacco control is analogous to treating an infection: sufficient dose of the right medicine must be applied for a sufficient duration of time in order to succeed.

The CDC's *Best Practices* document lays out how a comprehensive tobacco control program can be operationalized as a state program. Using evidence-based analysis of existing comprehensive state tobacco control programs and published evidence-based practices, the CDC provides guidance on the scale of funding necessary to support an effective tobacco control program, and presents state-specific funding ranges and programmatic recommendations. **It estimates that New York should spend between \$155.1 million and \$339.4 million every year on its comprehensive tobacco control program, with a median recommendation of \$254 million.**⁴³ Approximately a dime of every dollar of the annual revenue generated by tobacco would fund New York's tobacco control program at the median CDC-recommended level.

The CDC's *Best Practices* includes a detailed breakdown of programmatic spending within a tobacco control program. The following chart presents CDC's recommended funding level for each program element versus the reality of the most recent state budget.⁴⁴

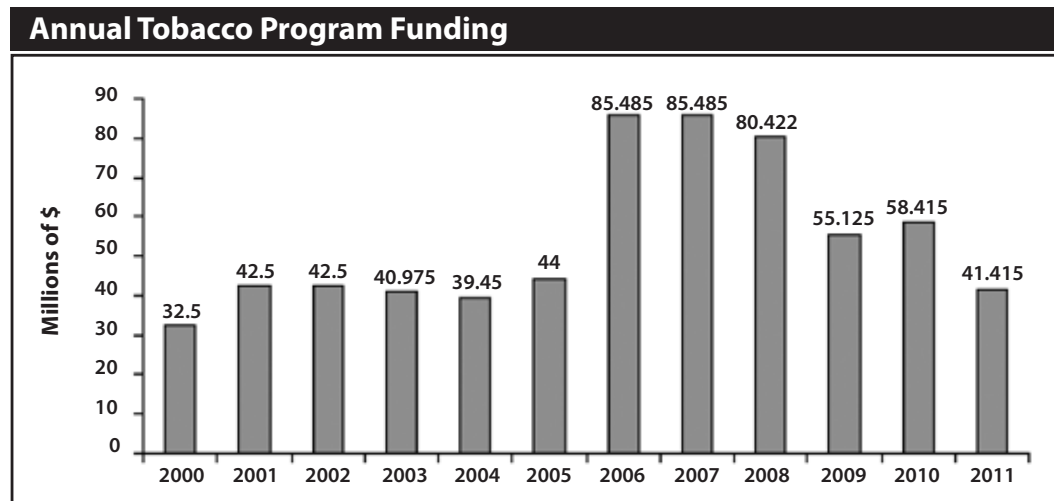
INTERVENTION	CDC RECOMMENDATION (Millions)	REALITY: NY FY 2011-12
TOTAL	\$254	\$41.4
STATE AND COMMUNITY	\$89.9	\$17.5
HEALTH COMMUNICATION	\$66.1	\$6.0
CESSATION	\$65.1	\$10.7
SURVEILLANCE AND EVALUATION	\$22.1	\$3.25
ADMINISTRATION AND MANAGEMENT	\$11.1	\$3.9

⁴³ Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs - 2007*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; October 2007, p. 54. See: http://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2007/BestPractices_Complete.pdf

⁴⁴ Ibid. p. 54, 55.

UP IN SMOKE: NEW YORK'S SPENDING ON PROGRAMS TO HELP SMOKERS TO QUIT AND KEEP KIDS FROM SMOKING

New York's Tobacco Use Prevention and Control Program is supported through annual state budget appropriations. Funding started in 2000 at \$32.5 million, peaked in 2006/07 at \$85.485 million, and has since precipitously declined to \$41.415 million in the current fiscal year. Spending is now lower than it was in the program's first full year of operation.⁴⁵



► CURRENT COMMUNITY-BASED ACTIVITIES

NY TCP funds organizations across the state to work in three modalities: Community Partnerships for Tobacco Control, Youth Action Programs (called "Reality Check"), and Tobacco-Free School Policy Programs.⁴⁶ Partnerships are charged with engaging, educating and mobilizing the community to strengthen tobacco-control policies. State and community interventions have long been an integral part of a comprehensive tobacco control program, and are a key element identified in the CDC's *Best Practices*. Every county in the state falls within the coverage area of a Partnership contractor.

Modality contractors are charged to effect policy change in multiple settings, including health care provider organizations; schools; licensed tobacco retailers; multi-unit housing; and public spaces, such as parks, beaches, and building entrance ways. A key indicator for this strategy is the adoption and effective implementation of local and statewide policies that permanently change society's acceptance of tobacco use and tobacco product marketing. CDC recommends that tobacco control programs emphasize tobacco regulation and policy over individually focused clinical or education interventions because policy changes potentially have the greatest reach.

For this strategy to have a meaningful effect on population-based measures of smoking initiation and cessation, two conditions must be met. First, the targeted policies must cover a significant proportion of the state's population. Second, the policies must either provide meaningful support for smoking cessation and prevention or constraints on the tobacco industry (e.g., reduce cigarette price promotions).

Community contractors conduct three types of activities. They use paid and earned media and other strategies to raise awareness and educate the community and key community members about the tobacco problem and tobacco control policies; educate government policy makers about the tobacco problem; and advocate with organizational decision makers, such as tobacco retailers, health care organizations, school boards, and community organizations, for policy changes and resolutions.

⁴⁵ Information provided by New York State Department of Health, Tobacco Use Prevention and Control Program.

⁴⁶ RTI International, *2010 Independent Evaluation Report for the New York Tobacco Control Program*, New York State Department of Health, August 2010.

While community coalitions can point to many successes, their impact has necessarily been limited by their ability to penetrate communities. Rural areas and disadvantaged neighborhoods are especially time and effort-intensive, and it is doubtful that the program has enough boots on the ground to impact a high proportion of the state's population. Clearly at least some, and arguably all, areas of the state are under served in that there is simply not enough person power working on the project.

► CURRENT CESSATION EFFORTS

The TCP funds Cessation Centers to increase the number of health care providers that have a system to screen all patients for tobacco use, provide brief advice to quit at all visits, and provide assistance to help patients quit successfully. Evidence demonstrates that brief advice to quit smoking by a health care provider significantly increases the odds that a smoker will quit. Cessation Centers use the Public Health Service clinical practice guideline [Treating Tobacco Use and Dependence](#) to guide their work. Cessation Centers partner with health care organizations across New York State and offer provider training, guidance on system improvement, and technical assistance to bring new organizations on board, including providing continuing education credits for tobacco cessation training. In 2010, Cessation Centers across New York State report working with 660 hospitals or hospital departments or units, 1,588 group practices, and 176 other organizations.⁴⁷

The New York State Smokers' Quitline provides individualized phone counseling seven days a week, prerecorded messages covering a range of stop-smoking topics; a Fax-to-Quit health care provider referral program; the Quitsite Web site; and the distribution of free 2-week nicotine patch starter kits to eligible callers. Quitlines and Web-based quitsites serve a number of purposes in a tobacco control program, including (1) providing an effective, evidence-based service for helping smokers quit smoking; (2) serving as a clearinghouse of information on smoking cessation for smokers, health care providers, and the general public; (3) providing a call to action in mass media messages designed to promote cessation; and (4) enabling health care providers to refer their patients to a helpful resource.

The core service of the Quitline is to provide support to those who call seeking to quit. The support is provided by a Quitline specialist who works with the smoker to develop a quit smoking plan, assess eligibility for and provide NRT, and send the smoker a packet of quit smoking information. The specialist contacts the caller again to offer encouragement, provide additional tips, and determine quit progress. The Quitline also offers additional coaching calls and NRT for Medicaid recipients and the uninsured.

In 2009, 110,724 current and former smokers (4.1% of adult smokers in New York State) received telephone counseling and 90,966 (3.4%) registered to receive free NRT through the Quitsite. Utilization of Quitline services is very much a function of public awareness created by advertising. The volume of calls increases and decreases as the program's advertising increases or decreases.⁴⁸

► CURRENT PUBLIC EDUCATION EFFORTS

The program invests in media (primarily television) messages targeting general audiences and smokers. The messages have addressed the dangers of smoking and the benefits of quitting, the dangers of second hand smoke, and the adverse impact of tobacco product marketing. Most messages New York uses were produced by tobacco programs in other states or other countries (including Australia and the United Kingdom), which means New York spends relatively little of its media budget on production, and most on message delivery. The City of New York has independently produced and aired anti-smoking messages on media in the city. The quality of New York's anti-tobacco advertising has won praise from marketing and public health experts, but in recent years the program's budget has been too limited to effectively deliver messages to the public.

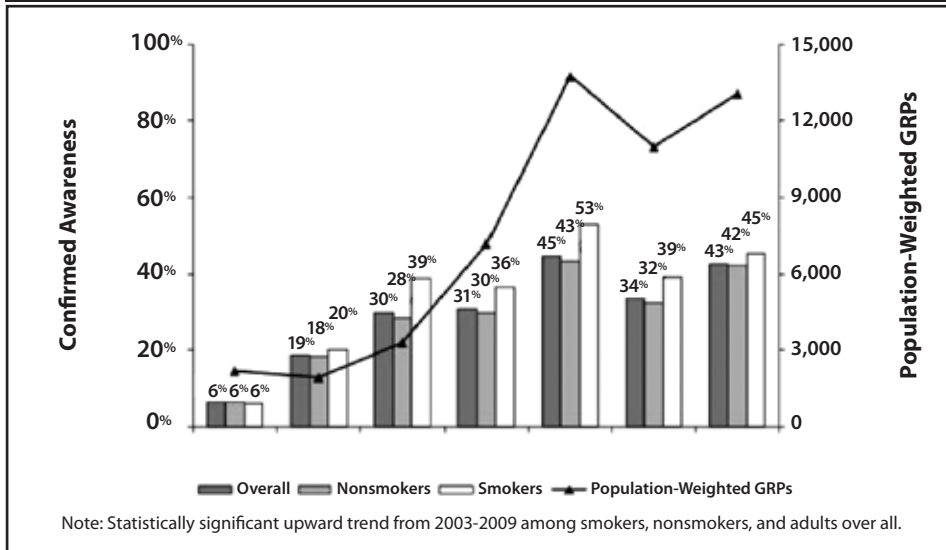
Between 2003 and 2007, as funding for the overall program rose, the level of spending devoted to purchasing advertising time/space increased. Then, in 2008, as the program's budget began shrinking, spending on mass media also declined. Gross rating points (GRPs) represent a standardized measure of a television audience's potential exposure to a media campaign. Overall, advertising increased fivefold from 2003 (21,959 GRPs) to 2007 (109,692 GRPs) and NY TCP's increased investment in mass media translated into significant increases in New Yorkers' awareness of advertisements over time. Confirmed awareness of NY TCP-sponsored advertisements among New York smokers increased from 6 percent in 2003 to 53 percent in 2007.⁴⁹

⁴⁷ RTI International, [2010 Independent Evaluation Report for the New York Tobacco Control Program](#), New York State Department of Health, August 2010, p.19.

⁴⁸ RTI International, [2010 Independent Evaluation Report for the Tobacco Control Program](#), New York State Department of Health, p. 26.

⁴⁹ RTI International, [2010 Independent Evaluation Report for the Tobacco Control Program](#), New York State Department of Health, p. 15

Confirmed Awareness of NY TCP Television Advertisements and Annual Gross Rating Points (GRPs), Adult Tobacco Survey 2003-2009



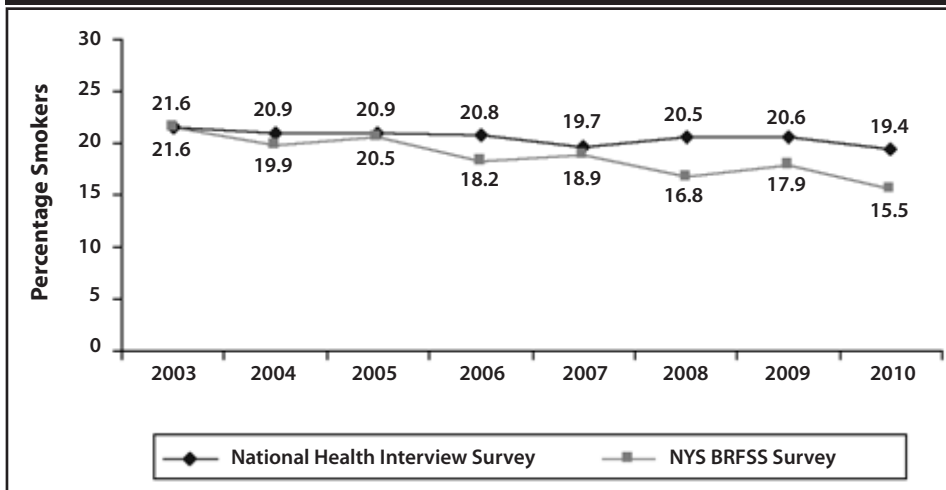
However, as the program began absorbing budget cuts, overall GRPs declined by 32.5 percent between 2007 and 2008, and there was a pronounced decline in awareness among smokers from its peak of 53 percent in 2007 to 39 percent in 2008. The decline in awareness coincides with the decline in advertising GRPs purchased in 2008. Media spending and awareness increased briefly in 2009, but since then, deeper budget cuts have further eroded the program's advertising spending and its ability to reach smokers with life-saving information. Furthermore, the lack of resources has made it harder to field communications targeting racial and ethnic minorities, non-English speakers and other hard to reach audiences.

► PUBLIC HEALTH BENEFIT OF NEW YORK'S TOBACCO CONTROL PROGRAM

New York's tobacco control program, combined with policy measures including a high tobacco excise tax and public smoking restrictions, has fostered a decline in the rate of tobacco use among both children and adults. Between 2000 and 2010, the prevalence of smoking among high school students fell steadily from 27.1 percent to 12.6 percent, a significantly faster rate than observed in the rest of the country.⁵⁰

Similarly, the adult smoking rate in New York has also fallen faster than in the U.S. as a whole, dropping from 21.6% in 2003 to 15.5% in 2010.

Adult Smoking Prevalence: NY vs. US

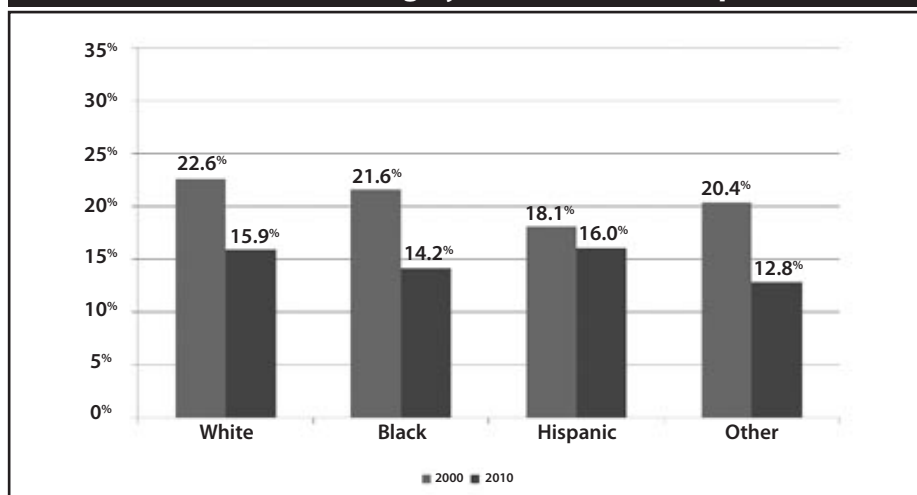


⁵⁰ New York State Department of Health. "Smoking among New York high school students continues to decline". *Stat Shot*, V4, No. 1. January 2011.

However, a closer analysis of the adult numbers shows that a large proportion of the excess decline in adult tobacco use is due to declines in smoking among those in their 20's. The prevalence of former established smokers, an indicator for the role of smoking cessation, has remained unchanged since 2000, with the exception of 25- to 34-year-olds. The prevalence of adults who have not smoked 100 cigarettes in their lifetime, an indicator for the role of prevention, significantly increased. This is an indication that the observed reduction in current cigarette use among young adults is driven by prevention efforts. In other words, the state has succeeded since 1999 in significantly increasing the proportion of children who do not grow up to become smokers, but has only marginally increased the rate of smoking cessation among established adult smokers.⁵¹

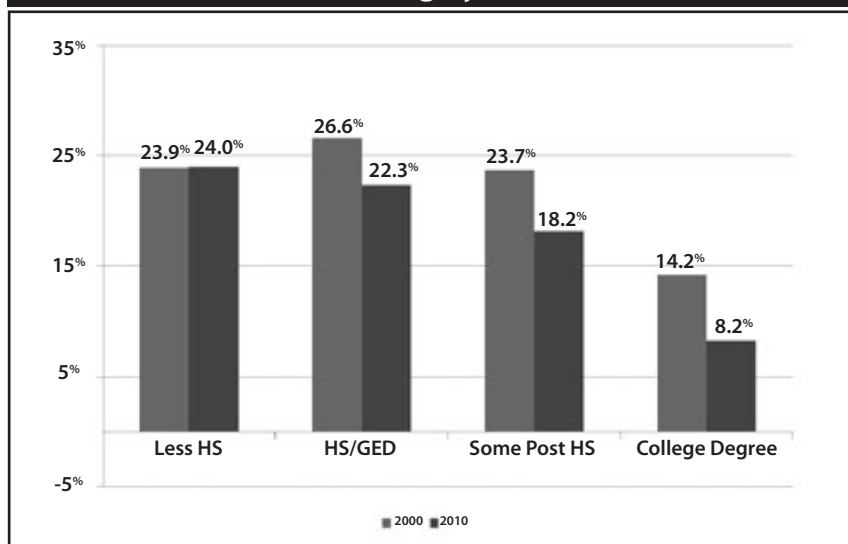
The decline in smoking has occurred about equally across all ethnic groups. There is now no significant difference among New York's major racial/ethnic groups in the adult prevalence of smoking.

Adult Prevalence of Smoking by Racial/Ethnic Group, 2000-2010⁵²



But the program has failed to have any impact on less educated, poorer segments of society. Smoking among those with less than a high school education was unchanged between 2000 and 2010, a period during which tobacco use significantly declined among all other groups with higher educational attainment. Those with less than a high school education now smoke at a rate three times that of college graduates.

Adult Prevalence of Smoking by Education, 2000-2010⁵³

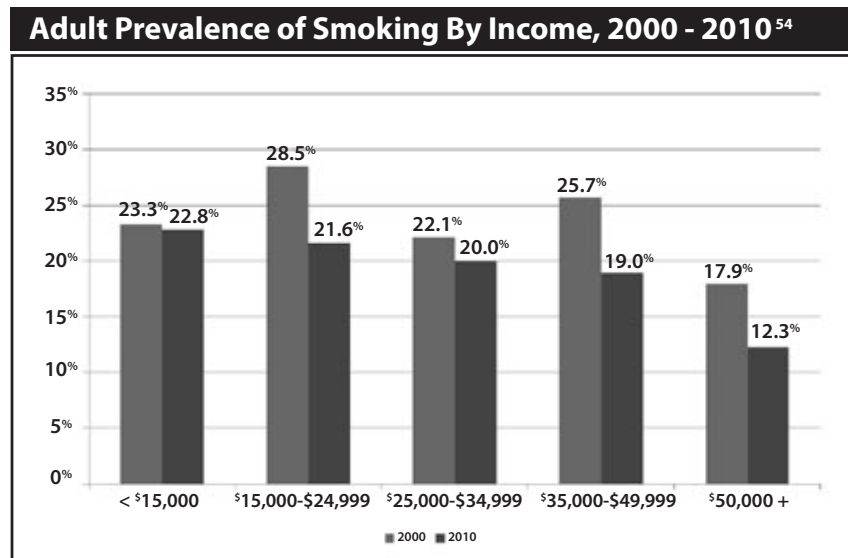


⁵¹ New York State Department of Health. *Youth Prevention and Adult Smoking in New York*. March 2011.

⁵² Information from New York Department of Health, Tobacco Use Prevention and Control Program.

⁵³ Information from New York Department of Health, Tobacco Use Prevention and Control Program.

Since 2000, smoking cessation rates have been greater, and smoking rates are now lowest, among New Yorkers with incomes over \$35,000 a year. Those with incomes below \$25,000 have the highest smoking rates, and smoking prevalence among the very poorest are practically unchanged in ten years.



Inadequate funding can substantially weaken the effectiveness of a tobacco control program. The poor are heavier consumers of mass media, especially television and radio, and can be reached through these channels. On those brief occasions when the TCP has conducted media campaigns at a level sufficient to penetrate these markets, it has experienced a significant increase in calls to the Quitline, mostly from lower income smokers. Because of insufficient funding, the program has not consistently reached the most disadvantaged elements of society (who can least afford to pay for cigarettes) and has not done enough to help smokers that want to quit.

In 2011, the Legislature adopted recommendations of the Medicaid Redesign Task Force and extended the smoking cessation counseling benefit to all adult Medicaid beneficiaries. The benefit provides six cessation counseling sessions within 12 contiguous months and prescription and non-prescription drug therapy (nicotine patches and gum, bupropion, varenicline). While this is a welcome expansion of the benefit, experience from Massachusetts, which took a similar step in 2006, shows that utilization of the benefit is directly related to promotion, especially through the mass media.

⁵⁴ Information from New York State Department of Health, Tobacco Use Prevention and Control Program.

UP IN SMOKE: RECOMMENDATIONS: FUND AND IMPROVE NEW YORK'S PROGRAM

Obviously, the state's tobacco control program needs more money. The experts at the CDC recommend it and it is quite clear that money is available. What is lacking is the will to invest in a program that can significantly reduce tobacco-caused death and disease, reduce health care costs and enhance the productivity of the state's workforce. The repeated cuts to the Tobacco Control Program's budget prevent it from implementing the type and intensity of interventions that would make it genuinely comprehensive in scope and impact. Therefore we recommend: **Incrementally increase Tobacco Control Program funding to the CDC-recommended level of \$254 million per year.** The program's annual budget should be increased to \$100 million in 2012-13 and then, as its capacity grows, increased by \$50 million every year until it reaches the CDC target appropriation.

Even with adequate funding, additional measures are needed.

Additional Reforms:

- ▶ **1. Target More Resources to Adult Cessation** - It is clear that achieving near-term reductions in tobacco use rates, and the incidence of tobacco-caused disease, will best be accomplished by encouraging adult smoker to quit. Treating tobacco dependence in adults is one of 20 priority areas targeted in a recent report from the National Academy of Sciences identifying ways to transform the healthcare system and translate knowledge into lifesaving clinical practice.⁵⁵ The National Task Force on Clinical Preventive Services ranks tobacco cessation second only to childhood immunizations in its list of priority preventive services.⁵⁶ Only by motivating smokers to attempt to quit smoking and providing the pressure, resources, and support to make those attempts successful will smoking rates decline, disease rates decline, premature deaths decline, and economic savings accrue. Most smokers want to quit, and encouraging and assisting adult cessation is a cost-effective tobacco control strategy.
- ▶ **2. Increase Community Level Interventions, Especially in Disadvantaged Neighborhoods and Rural Areas** - To change social norms a program must be well integrated into a community. Program personnel must understand and, preferably, live in, the communities they work in. This can only be done by increasing the number of community-based TCP contractors working in a coordinated manner to achieve program goals. CDC recommends that about 35% of Program funding be devoted to community activities. The program has done a good job of maintaining the community interventions it had before budget cuts began, but 35% of such a small budget is not enough to serve a diverse state of 19 million people. At least one-third of any budget increase should be directed to increasing the level of community activity.
- ▶ **3. Increase the Proportion of Funding Dedicated to Health Communications** - CDC recommends that 25% of the Program budget be dedicated to media interventions, but the TCP currently spends only 14% of its budget on media (much of the difference has been appropriately directed to preserving community programs). This is simply not enough to effectively reach the general public, let alone develop and implement communication strategies to reach racial and ethnic minorities, those living in rural areas, non-English speakers and other hard to reach audiences. As quickly as possible, the TCP should increase its media budget to \$66 million a year and target messages to those the program has not been reaching.
- ▶ **4. Develop and Implement Strategies for Reaching Those With Mental Illness or Addictive Disorders** - People with mental illness smoke at a rate almost twice that of the general public. Nearly half the cigarettes smoked in the United States are consumed by people with co-occurring psychiatric or addictive disorders.⁵⁷ The New York TCP has done pioneering work in this field, partnering with the Office of Alcoholism and Substance Abuse Services, to make treatment center smoke free, train addiction counselors in smoking cessation and make nicotine replacement therapy available to clients. More recently it has worked with the Office of Mental Health to begin integrating tobacco control interventions into mental health systems. Clearly, this is an important initiative that must be enhanced if we are to eliminate the scourge of tobacco-caused disease. Additional funding should be provided to the TCP to further support its work with these and other providers serving this and other disadvantaged populations, such as Federally Qualified Health Clinics and safety net hospitals, with the focus of enhancing support for patients that use tobacco.

⁵⁵ Institute of Medicine, Board on Health Care Services, *Priority Areas for National Action: Transforming Health Care Quality*, 2002.

⁵⁶ Ashley B. Coffield, Michael V. Maciosek, J. Michael McGinnis, Jeffrey R. Harris, M. Blake Caldwell, Steven M. Teutsch, David Atkins, Jordan H. Richland, Anne Haddix, "Priorities among recommended clinical preventive services", *American Journal of Preventive Medicine* 21 (1) (2001) pp. 1-9.

⁵⁷ *A Hidden Epidemic: Tobacco Use and Mental Illness*. The Legacy Foundation, June 2011, p 4.

