

Medical Student Activism: A Primer on Domestic and International Tobacco Control

Introduction

The tobacco pandemic has emerged as one of the gravest problems facing the international community of health-care professionals today. Barring a reversal of current trends, tobacco is expected to become the leading global killer in 20- to 30-years' time. Despite the profusion of research documenting the rise in tobacco-related morbidity and mortality, efforts in control and prevention have lagged behind the spread of tobacco use. Health-care professionals and policy makers must dramatically expand their work in this area to stem the devastating sequelae of tobacco use.

This primer, produced by the American Medical Student Association, attempts to provide 1) an overview of the domestic and international harms resulting from tobacco use and its promotion by multinational corporations; 2) a timeline of key events; 3) and an introduction to available resources.

Health Effects of Tobacco Use

With the first modern blended cigarette (Camels) in 1913 came advertising campaigns that exploited health themes to promote consumption. Common phrases seen on billboards included "scientifically proved less irritating" (Philip Morris); "Reach for a Lucky instead of a Sweet" (Lucky Strike); "Can never stain your teeth!" (Viceroy); "The one cigarette that can show you proof of greater health protection" (Kent); and so forth.¹ Scientific evidence contradicting these claims has continued to accumulate since then.

Tobacco use is now linked to nearly 25 diseases, including heart disease, atherosclerotic peripheral vascular disease, laryngeal cancer, oral cancer, esophageal cancer and chronic obstructive pulmonary disease. Furthermore, tobacco use often has unintended negative health effects on those who do not smoke and has been linked to intrauterine growth retardation and low birth weight. Involuntary inhalation of cigarette smoke, known as environmental tobacco smoke (ETS) or "secondhand smoke," was the focus of yet another U.S. Surgeon General's Report in 1986. More recent risk assessments have confirmed the association between ETS and a host of pediatric and adult diseases including lung cancer, asthma, lower respiratory infections, decreased pulmonary function, sudden infant death syndrome, nasal sinus cancer and ear infections.^{4,5,7}

The Costs of Smoking

While Philip Morris appeared to acknowledge in October 1999 the health hazards of cigarette smoking—including lung cancer, heart disease and emphysema—the U.S. government and public alike have been aware of these dangers for years.⁸ Yet Americans continue to smoke. During 1998, the median prevalence of current cigarette smoking in the U.S. was 22.9 percent, ranging from 14.2 percent in Utah to 30.8 percent in Kentucky.⁹ More than one-half of U.S. households contain at least one smoker,¹⁰ and approximately 43 percent of children younger than 11 years of age are regularly exposed to ETS.¹¹

The societal costs are quite substantial, as tobacco use is one of the most prominent contributors to premature mortality in the U.S. One study estimated that, in the U.S. in 1990, approximately 400,000 deaths were attributed to tobacco.¹² Consideration of these numbers in comparison to other health harms, however, is what gives the health-care professional a true sense of perspective: these tobacco-attributable deaths outweighed the *combined* harms of alcohol consumption, microbial

agents, toxic agents, illicit drug use, firearms, motor vehicle accidents and the human immunodeficiency virus.¹³

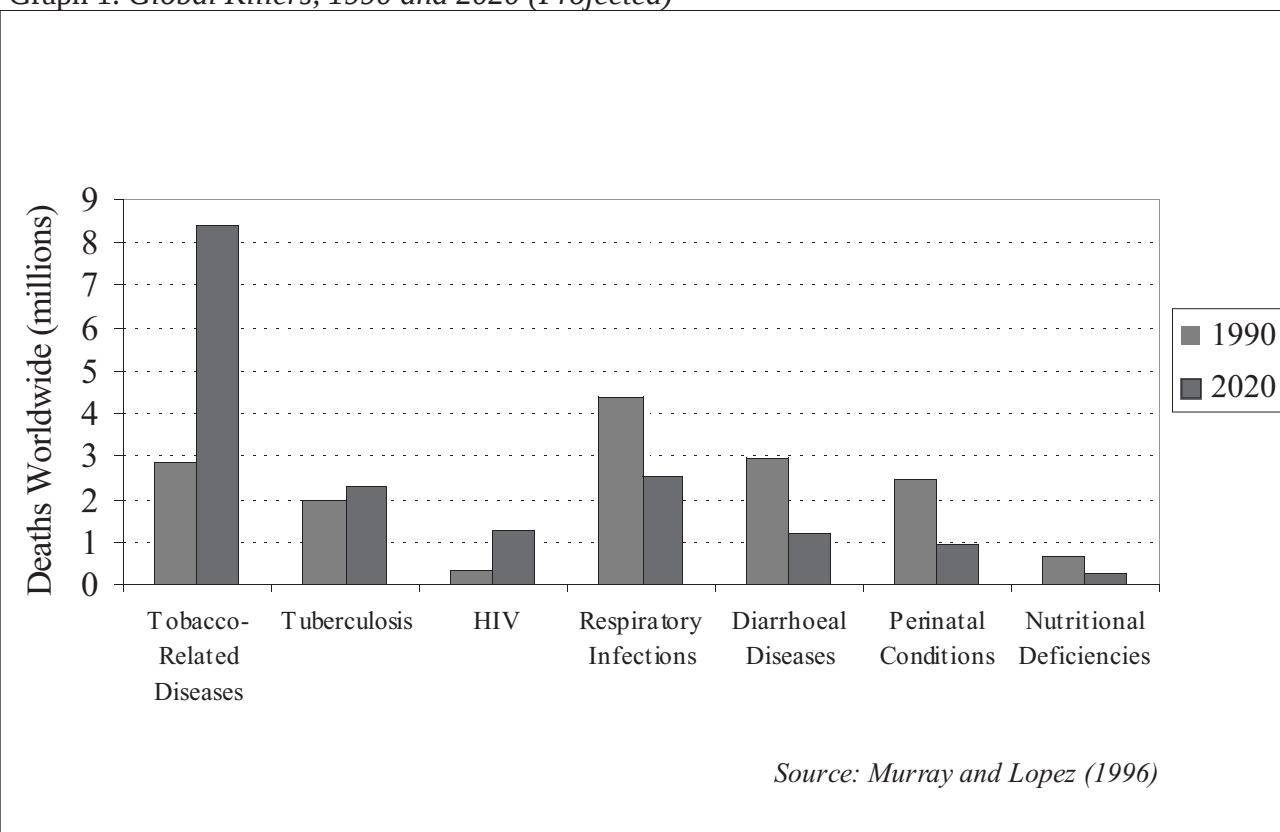
The monetary costs resulting from cigarette smoking have been estimated in various studies to constitute between 6 percent and 14 percent of all annual personal health-care expenditures in the U.S.,¹⁴ with \$50 billion in annual expenditures a commonly cited figure.¹⁵ Annual medical care costs attributable to children's involuntary exposure to ETS in the U.S. are estimated at nearly \$5 billion.¹⁶ Medical care costs of this magnitude may jeopardize the solvency of many developing countries' health-care systems. A recent World Bank report estimates that China and India would have to maintain GDP growth of at least 7 percent per year for the next 20 years—a substantial and perhaps unrealistically consistent pace—just to keep up with the economic burden tobacco promises to inflict upon their health-care systems.¹⁷

Tobacco as an International Health Problem

The forces of globalization have ensured the spread of the cigarette beyond U.S. borders, threatening to overburden health-care systems in developing countries already charged with the immense responsibility of keeping communicable diseases at bay. Tobacco use presents a grave enough threat to the global burden of disease that the World Health Organization (WHO) designated tobacco, along with malaria, as one of its top two cabinet-level priorities in 1998.

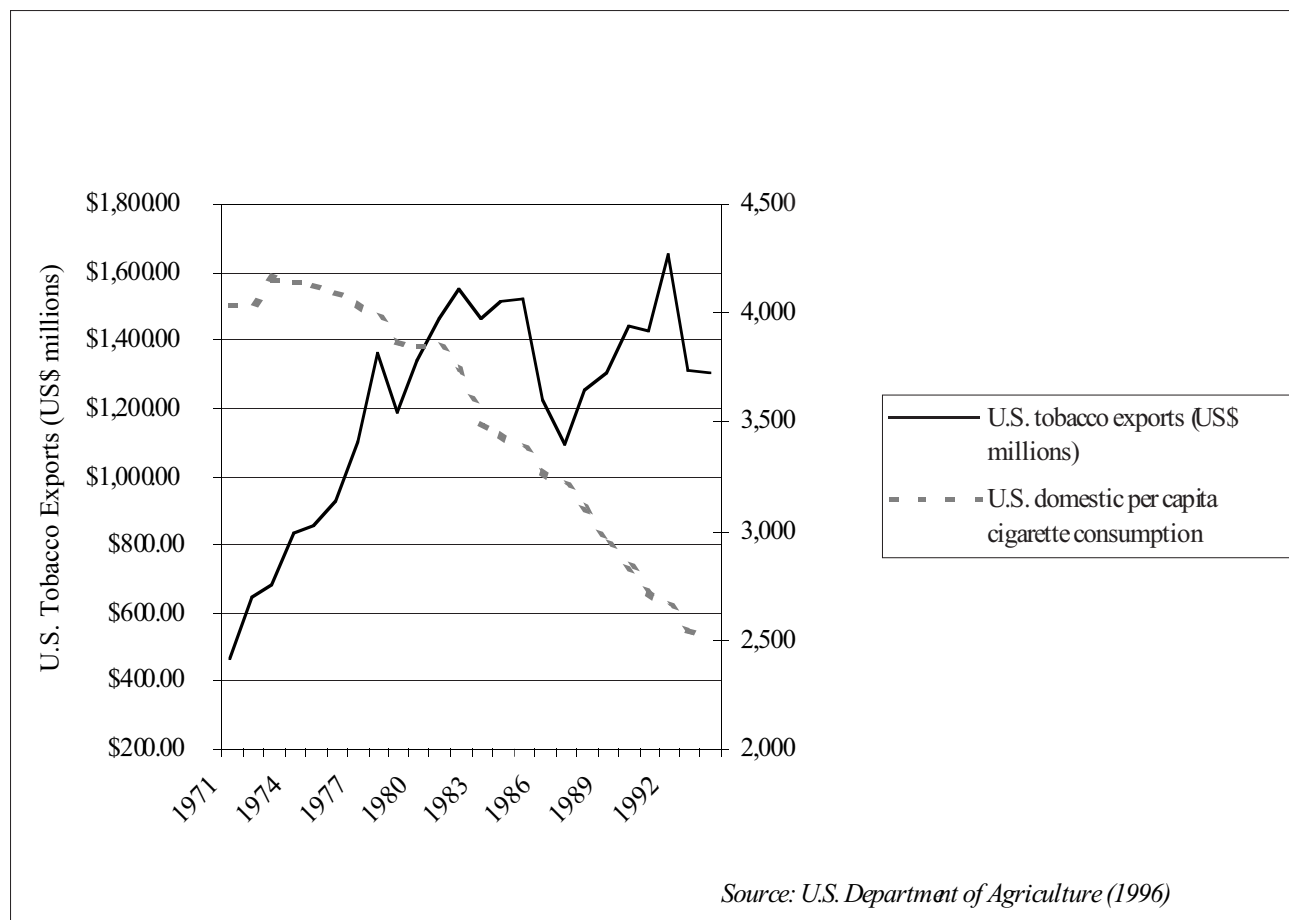
Worldwide, tobacco-related diseases claimed three million lives in 1990, and the annual death toll is expected to rise to 10 million lives by 2020.¹⁸ Now responsible for one in 10 deaths annually, tobacco-related diseases will soon account for one in every six deaths.¹⁹ As is apparent in **Graph 1**, this far outpaces the *combined* total of lives lost to tuberculosis, HIV, respiratory infections, diarrheal diseases, perinatal conditions and nutritional deficiencies.²⁰

Graph 1. *Global Killers, 1990 and 2020 (Projected)*



Reacting to heightened tobacco control activities and declining consumption at home, the U.S. tobacco industry has tripled its cigarette exports over the past two decades.²¹ For example, in 1997, Philip Morris, the world's largest cigarette maker, sold 711.5 billion cigarettes internationally compared to 235.2 billion cigarettes domestically.²²

Graph 2. *Trends in U.S. Tobacco Exports and Domestic Consumption*



Concurrent with the dramatic rise in U.S. cigarette exports, consumption of tobacco in developing countries doubled over the past two decades.²³ This rise in consumption will be paralleled by a shift in the tobacco-related burden of disease to developing countries. Today, more than one-half of tobacco-related deaths occur in the developed world, but by 2025, 70 percent of these deaths will occur in developing countries.²⁴

Tobacco Advertising and Promotion

Advertising and promotion are perhaps the strongest forces that stimulate cigarette consumption among women, children, minorities, and other potentially vulnerable populations worldwide. The industry's promotional efforts in 1997 totaled \$5.6 billion in the U.S. alone.²⁵ In particular, industry documents confirm the targeting of youth in their overall strategy. In 1984 one R.J. Reynolds researcher wrote,

Younger adult smokers are critical to RJR's long-term performance and profitability. Therefore, RJR should make a substantial long-term commitment of manpower and money dedicated to younger adult smoker programs.... If

*younger adults turn away from smoking, the industry must decline, just as a population which does not give birth will eventually dwindle.*²⁶

Targeted populations are undeniably affected by tobacco advertising. Almost 90 percent of adults who have ever been regular smokers began smoking at or before the age of 18.²⁷ One cross-sectional analysis found that “youth” cigarette brands were more likely than “adult” brands to be advertised in magazines with a greater youth readership.²⁸ Teenage youth are twice as likely as adults to smoke the most heavily advertised cigarette brands: Marlboro, Camel and Newport.²⁹ A study conducted in Hong Kong found that one of the strongest risk factors for youth smoking was the youth’s perception of cigarette advertisements as attractive.³⁰ Another study suggests that tobacco advertising and promotion have a greater influence than even peer pressure on teen decisions to smoke.³¹ Even the youngest children are not spared the effects of tobacco advertising: one study found that 30 percent of three-year-olds and 91 percent of 6-year-olds could identify “Joe Camel” as a symbol of smoking.³²

We did not look at the underage market even though I am holding a document in my hand that says we did.
— James Morgan, former president and CEO of Philip Morris’s domestic tobacco unit, in a deposition recorded September 1997

Women and minorities are similarly targeted and affected. A 1995 Philip Morris internal memorandum entitled “Marlboro Women” clearly shows that the marketing of “light” cigarettes is an effort directed solely at women.³³ In 1968, the first “women’s cigarette” was introduced in the U.S. Within six years, smoking prevalence among teenage girls nearly doubled, while male smoking prevalence remained unchanged.^{34,35} Tobacco companies highlight racial identity themes in their promotional efforts, including: Hispanic street fairs in Los Angeles sponsored by RJR; “Kool Achiever” awards presented by Brown & Williamson; jazz concerts, Alvin Ailey American Dance Theatre and photographic displays of Dr. Martin Luther King, Jr., sponsored by Philip Morris. The sharpest increases in smoking prevalence in the U.S. are reported among African-American youth, where rates increased 80 percent from 1991 to 1997; among Hispanic youth over the same period, prevalence increased by 34 percent.³⁷

Since the 1969 Public Health Cigarette Smoking Act, which resulted in the withdrawal of cigarette advertisements from radio and television, domestic tobacco control activities in the area of tobacco advertising have heightened. For example, in 1997 the U.S. Federal Trade Commission banished Joe Camel from U.S. media. Notably, however, the recent settlement of the state lawsuits, while containing measures that address some of the key issues domestically, is silent with regard to many international health issues. As noted previously, the tobacco industry has long begun to turn its eye toward overseas markets.

In several instances in the 1980s, American entry into foreign cigarette markets was directly facilitated through the Office of the U.S. Trade Representative (USTR).³⁸ Section 301 of the Trade Act of 1974 authorized the USTR to launch a full-scale investigation of “unfair trading practices” by other nations, binding the U.S. government to invoke retaliatory sanctions within a year if changes were not made. The experiences of Japan, Taiwan and South Korea in particular illustrate what the tobacco industry could accomplish with government assistance. After Japan succumbed to the USTR’s pressure in 1985 and opened up its market to U.S. cigarette makers, smoking prevalence among Japanese women doubled.³⁹ The USTR again deployed Section 301, this time against Taiwan in 1986, resulting in a doubling of smoking prevalence among teenage males and a 13-fold increase

in smoking prevalence among teenage females.⁴⁰ One year after U.S. cigarette makers, under the cover of Section 301, entered South Korea's market in 1988, smoking prevalence among teenage males doubled and nearly quadrupled among teenage females.⁴¹

Armed with considerable resources, U.S. tobacco companies often take advantage of the regulatory lag in foreign markets and circumvent local ordinances with relative ease in many cases. **Box 1** provides details on a few examples.

Box 1: Eluding Advertising Restrictions Around the World

Examples of the tobacco industry's predations are in no short supply. Circumvention of direct advertising restrictions usually takes one of four forms of indirect advertising: (1) "brand-stretching," or using brand or company names on other goods and services such as clothes, apparel, and coffee shops; (2) sponsorship of sports, the arts, pop and rock concerts, university departments, and even health organizations; (3) product placement, or the paid insertion of smoking or tobacco emblems into film narratives; and (4) use of media to enhance the industry's image, such as through "good corporate citizens" charity and relief efforts.

A number of excellent investigative reports have documented the most egregious of these violations, and some of them are provided here.^{81,82,83,84}

- The city of Bucharest allowed R.J. Reynolds to add the Camel logo to the yellow traffic lights in exchange for a year's supply of light bulbs.
- To bypass Sri Lanka's ban on domestic advertising, BAT in 1996 introduced its Benson & Hedges brand on a televised cricket match from Australia where the Sri Lankan national team, the defending world champion, was playing.
- BAT has promoted its Benson & Hedges brand in Sri Lanka by sponsoring discos. Young, attractive women ("golden girls") hand out cigarettes and encourage customers to smoke them, while a laser light traces "Benson & Hedges" on the walls.⁸⁵
- In 1997, Philip Morris sent a traveling disco to the Siberian city of Novosibirsk with processional dancers, an elaborate light and sound system and staff dressed in Marlboro gear. The price of admission was five empty packs of Marlboros—three for students.
- In Argentina in 1996, playing cards redeemable for prizes were inserted into packs of Camel cigarettes, and advertisements went up in buses for Joe Camel and the Hard Pack Blues Band. Sales of Camel cigarettes shot up 50 percent.
- According to the Vietnamese Ministry of Health, at Hanoi's 1998 national New Year's celebration, Philip Morris had "a large tent with Marlboro horses to ride on for children, and young, nicely dressed cowboy girls offered single cigarettes free of charge to young boys."⁸⁶

A recent study on the U.S. tobacco companies' cigarette package labeling practices documented that smokers in developing countries have been systematically deprived of health information supplied to American smokers. Cigarette package warning labels were more commonly found and of higher quality and greater stringency in developed countries.⁴² This health information disparity poses a threat to the uninformed consumer, as informative cigarette package warning labels have

been found to play an important role in smoking cessation campaigns worldwide.⁴³ In contrast, in China—where 50 million of the nation’s 320 million smokers claim they want to quit—only 40 percent of both smokers and nonsmokers surveyed were aware that smoking could cause lung cancer, and only four percent knew that smokers were at greater risk for heart disease.⁴⁴

*We are not encouraging the Chinese to smoke.
They all smoke like chimneys anyway. We just
want them to smoke our brands.*
— Lord Swaythling, Chairman of Rothmans International NV, 1993

Not only are cigarettes likely to be marketed differently in developed vs. developing countries, but also the cigarette itself may be manufactured differently in developed vs. developing countries. One study observed that some cigarette brands sold in Africa had tar and nicotine levels comparable to brands marketed in the U.S. 20 years before.⁴⁵ Furthermore, other documentation studies show that the identical cigarette brands sold in developed countries contain more tar and nicotine when sold in developing countries.^{46, 47}

Nicotine Addiction and Smoking Cessation

On April 14, 1994, executives of the seven largest U.S. tobacco companies swore in Congressional testimony that nicotine is not addictive and denied manipulating nicotine levels in cigarettes. The recent debut of Philip Morris’ putative “admission” notwithstanding, tobacco companies have known for decades that nicotine is an addictive substance. For example, in a July 17, 1963, internal memorandum Addison Yeaman, general counsel for Brown & Williamson, freely accepted that “we are...in the business of selling nicotine, an addictive drug.”⁴⁸ In 1988, after an extensive review of the scientific literature, the office of the U.S. Surgeon General released a report that concluded, “The pharmacologic and behavioral processes that determine tobacco addiction are similar to those that determine addiction to drugs such as heroin and cocaine.”⁴⁹

The addictive nature of nicotine has a significant impact on tobacco users, who often regret beginning the habit in the first place. Perhaps most striking is the fact that 70 percent of U.S. smokers report they want to quit and have made at least one self-described serious attempt to do so.⁵⁰ This amounts to approximately 20 million quit attempts in the U.S. per year.⁵¹ Regret runs high across the spectrum of countries, both developing and developed, worldwide. Unfortunately, regret does not always translate into successful cessation of smoking. In most high-income countries, the prevalence of male former smokers who have quit successfully hovers around 30 percent.⁵² In stark contrast, ex-smokers are more rarely found in developing countries such as China (2 percent), India (5 percent) and Vietnam (10 percent).⁵³

One of the biggest barriers to smoking cessation is that the provision of such health-care services lags behind the needs of the population. Surveys of U.S. smokers indicate that physician advice is important in motivating quit attempts,⁵⁴ but of smokers who see a physician at least once per year, less than half of them report having ever been asked about their smoking status or been urged to quit.⁵⁵ Consequently, nine out of every 10 smokers in the U.S. try to quit “cold turkey” on their own, with a long-term success rate of only five percent.⁵⁶ Furthermore, only one percent of participants in the Direct Observation of Primary Care Study were observed to have received information on how to reduce nonsmokers’ exposure to ETS,⁵⁷ with the result that children continue to suffer from the effects of parental smoking.

While the family practitioner office visit lasts an average of 10 minutes,⁵⁸ effective smoking cessation interventions which follow the U.S. Agency for Health Care Policy and Research (AHCPR) Clinical Practice Guideline require only three minutes or less of practitioner time.⁵⁹ Even

brief, minimal-contact interventions delivered during the course of routine patient care can have a significant impact on patient cessation efforts.^{60, 61} Children's exposure to ETS can be reduced by similarly brief parental counseling interventions.^{62, 63}

Box 2: Health Benefits of Smoking Cessation

The individual health benefits that accrue from smoking cessation are substantial. Selected conclusions from the 1990 Surgeon General's Report include:

- Persons who quit smoking before age 50 have one-half the risk of dying in the next 15 years, compared with continuing smokers.
- After 10–15 years of smoking abstinence, risk of all-cause mortality returns nearly to that of persons who have never smoked.
- The excess risk of coronary heart disease caused by smoking is reduced by about half after one year of smoking abstinence and then declines gradually. After 15 years of abstinence, the risk of coronary heart disease is similar to that of persons who have never smoked.
- Women who stop smoking before becoming pregnant have infants of the same birth weight as those born to non-smokers.
- Average weight gain as a result of smoking cessation is only about five pounds. Only about 3.5 percent of those who quit smoking gain more than 20 pounds.

Where to Begin?

Medical school provides an opportunity for future physicians to be trained in smoking cessation techniques.⁶⁴ Clinical trials demonstrate that physicians who have received training in smoking cessation techniques are more effective in counseling patients to quit than physicians who have not been similarly trained.^{65, 66} The National Cancer Institute (NCI) recommended in 1992 the integration of effective smoking cessation and prevention interventions into all U.S. medical school curricula.

Actual implementation has fallen far short of those goals. The most recent assessment of the content and extent of tobacco curricula in U.S. undergraduate medical education provides documentation that only 55 percent of medical schools cover all basic science content areas as recommended by the AHCPR Clinical Practice Guideline and the NCI Expert Panel. Little over 30 percent of medical schools provide training for smoking cessation skills in the latter two clinical years.⁶⁷

As a result, new physicians are not adequately prepared to deal with nicotine dependence. According to one 1991 survey, only 21 percent of practicing physicians felt that they had been properly trained to help their patients stop smoking.⁶⁸ In other survey studies, large proportions of pediatricians have reported a lack of confidence in their ability to counsel parents of their patients to stop smoking.^{69, 70, 71}

The benefits of curricular change and enhanced training could be substantial. If the AHCPR Clinical Practice Guideline were fully implemented – that is, if primary care clinicians were to screen all presenting adults for smoking status and advise and motivate all smokers to quit during the course of a routine office visit or hospitalization—society could expect to gain 1.7 million quitters in the first year at a cost of only \$6.3 billion.⁷²

The Potential to Effect Change

As an organization composed of more than 30,000 physicians-in-training, AMSA offers a significant grassroots force for mobilizing on the issue of tobacco control in the U.S. and abroad. This effort has already begun domestically through AMSA's sponsorship of national initiatives on tobacco control ("Stamp Out Smoking") in 1997-1998, and, more generally, on substance abuse in 1999-2000. Ongoing local AMSA projects in tobacco control continue to strive toward reducing the use of tobacco in the U.S.

Tobacco control projects designed by other organizations serve as additional examples of successful initiatives. Doctors Ought to Care, a Houston-based organization with active chapters nationwide, is committed to increasing public awareness on health issues such as tobacco, notably through media literacy and media advocacy. The American Academy of Family Physicians has worked with medical student groups, notably through their Tar Wars youth smoking prevention and education program. Other grassroots groups with a national presence—such as Americans for Non-Smokers' Rights, American Cancer Society, American Heart Association, and American Lung Association—have mobilized on various aspects of tobacco use prevention and control.

AMSA is currently doing exploratory work on establishing a multi-year effort, through the AMSA Foundation, that will address both domestic and international aspects of tobacco use prevention and control. On the domestic side, these activities could include educating medical students about the global harms from tobacco use and its promotion by transnational corporations, training students to heighten awareness in their communities about the need for effective local tobacco control programs, and advocating for effective teaching of tobacco use prevention and cessation in medical school curricula.

On the international side, AMSA could provide a framework on which to build partnerships that bridge the work of AMSA chapters domestically and medical student groups internationally working on tobacco control. Just as the lessons of domestic work can aid medical students in developing countries in their tobacco control efforts, success stories in grassroots activity by student groups abroad can inform the development of projects here in the U.S. An organized buddy program between AMSA chapters and medical schools in developing countries may facilitate this joint enterprise and the fruitful development of projects in partnership.

As future physicians-in-training, medical students are uniquely positioned to address the health harms posed by tobacco use, both at the level of the individual patient encounter and for the broader mission of safeguarding the public health. AMSA can complement existing clinically-oriented efforts, such as the AHCPR Clinical Practice Guideline and NCI Expert Panel, by highlighting the importance of community involvement early on in the trajectory of physician training. Together, AMSA's initiatives will bring into a usable context for medical students the broad sweep of information presented in this primer, as well as foster constructive institutional change on an issue that has heretofore not received the critical attention it deserves.

Timeline of Significant Events

1950

Study by Richard Doll and Austin Bradford Hill linking smoking and lung carcinoma released.⁷³
Ernest Wynder and Evarts Graham release study linking smoking and bronchiogenic carcinoma.⁷⁴

1954

Tobacco industry faces first liability lawsuit by lung cancer victim alleging negligence and breach of warranty. Suit dropped 13 years later.

1964

The Advisory Committee to the U.S. Surgeon General releases a landmark report⁷⁵ concluding that cigarette smoking is a cause of lung cancer and laryngeal cancer in men, a probable cause of lung cancer in women, and the most important cause of chronic bronchitis. The U.S. Federal Trade Commission issues a Trade Regulation Rule on Cigarette Labeling and Advertising requiring all cigarette packages and advertisements to carry the warning statement, "Cigarette Smoking is Dangerous to Health and May Cause Death from Cancer and Other Diseases."

1965

U.S. Congress pre-empts the FTC Trade Regulation Rule and passes the Federal Cigarette Labeling and Advertising Act, mandating the attenuated warning statement, "Caution: Cigarette Smoking May Be Hazardous to Your Health." The Act also prohibits any warning labels in cigarette advertising for at least four years.

1969

FCC issues a notice of proposed rule-making to ban cigarette advertising from radio and television and require all cigarette advertising to contain the warning statement, "Cigarette Smoking is Dangerous to Health and May Cause Death from Cancer, Coronary Heart Disease, Chronic Bronchitis, Pulmonary Emphysema, and Other Diseases."

1970

U.S. Congress pre-empts the FCC proposed rule and passes the Public Health Cigarette Smoking Act of 1969, which amends the Federal Cigarette Labeling and Advertising Act of 1965, mandating that all cigarette packages must bear the attenuated warning statement, "The Surgeon General Has Determined That Cigarette Smoking is Dangerous to Your Health."

1971

In accordance with the Public Health Cigarette Smoking Act of 1969, cigarette advertisements are withdrawn from radio and television.

1987

Smoking is banned at the World Health Organization.

1988

The office of the U.S. Surgeon General releases a report concluding that nicotine is an addictive drug, likening it to heroin and cocaine in its addictive properties.⁷⁶

1989

The USTR deploys Section 301 of the 1974 Trade Act against Thailand on behalf of the U.S. Cigarette Export Association. An explosion of opposition from health and consumer groups, as well as from the international community, forces the USTR to submit to arbitration by the General Agreement on Tariffs and Trade (GATT). In the landmark case, GATT rules that the Thailand market must open to foreign cigarettes but that stringent tobacco control measures can be implemented as long as they apply equally to domestic and foreign cigarettes.

1991

The World Bank announces a policy that it will no longer lend directly or indirectly for, invest in or guarantee loans for tobacco production, processing or marketing.

May 1994

Mississippi files the first state lawsuit seeking compensation from tobacco companies for smoking-related Medicaid costs.

August 1995

The Food and Drug Administration (FDA) proposes regulation to prohibit the sale and regulate advertising of cigarettes and smokeless tobacco to minors. The next day, the nation's five largest tobacco companies, joined by six advertising trade groups, file separate lawsuits challenging the proposed FDA rule.

March 1996

The Liggett Group, the smallest of the major tobacco companies, settles with each of the 22 states that had filed suit to recover Medicaid costs of treating smoking-related diseases.

August 1996

Final FDA rule and jurisdictional determination published. FDA rule bans cigarette-vending machines, self-service displays and free samples; requires retailers to age-verify purchasers who appear younger than 27 years of age; and imposes numerous advertising restrictions, notably banning advertising near schools and sponsorship of events.

April 1997

U.S. Federal District Court Judge upholds some of the FDA rule provisions, but tobacco advertising continues.

June 1997

Landmark 25-year, \$368 billion settlement proposed between the largest tobacco companies and attorneys general representing 40 states.

July 1997

Mississippi is the first state to settle with tobacco companies Brown & Williamson, R.J. Reynolds, Philip Morris and Lorillard. From August 1997 to May 1998, Florida, Texas, and Minnesota all reach separate agreements with the tobacco companies.

November 1997

The McCain Committee bill, S.1415rs, is first introduced (see "Frequently Asked Questions for details).

January 1998

Tobacco industry executives provide Congressional testimony that nicotine is addictive and that smoking may cause cancer.

May 1998

Tobacco is designated, along with malaria, as one of the World Health Organization's (WHO) top two cabinet-level priorities by Director-General Dr. Gro Harlem Brundtland. Dr. Brundtland establishes the Tobacco Free Initiative (TFI) to coordinate an improved global strategic response to tobacco. Under the umbrella of the TFI, the WHO begins to build strong partnerships with a number of international organizations, including UNICEF, United Nations Radio, the World Bank, the U.S. Centers for Disease Control and Prevention (CDC), the U.S. Environmental Protection Agency (EPA), the U.S. National Institutes of Health (NIH), and the International Development Research Center (IDRC)/Research for International Tobacco Control (RITC).

June 1998

Senate kills the McCain Committee bill.

August 1998

U.S. Fourth Circuit Court of Appeals strikes down the FDA rule, 2-1. The case is referred to the U.S. Supreme Court and is now pending.

November 1998

Forty-six states – excluding the four states that had reached separate agreements – reach a 25-year, \$206 billion “Master Settlement Agreement” (MSA) with cigarette makers over Medicaid costs for treating sick smokers.

March 1999

The U.S. Agency for International Development (USAID) announces its Policy on Tobacco, which ceases support for tobacco growth and related activities that promote tobacco production and use and declares support for other international community policy and programmatic efforts to curb tobacco production, processing, marketing and use.

May 1999

The World Bank releases “Curbing the Epidemic: Governments and the Economics of Tobacco Control,” a comprehensive report examining the economics of tobacco control.

September 1999

The U.S. Department of Justice files suit against the tobacco industry to recover billions of Medicare dollars spent on smoking-related diseases. The U.S. Attorney General accuses cigarette makers of waging “an intentional and coordinated campaign of deceit.” Case is expected to go to trial in 2003.

October 1999

World Health Organization Director-General Dr. Gro Harlem Brundtland appoints independent experts to review the extent of the tobacco industry's influence over United Nations organizations. WHO also convenes the first Working Group on the Framework Convention on Tobacco Control.

Frequently Asked Questions

What is the “Master Settlement Agreement?”

In May 1994, Mississippi filed the first state lawsuit seeking to recover monies from tobacco companies for smoking-related Medicaid costs. Other states rapidly followed suit. Eventually, on June 20, 1997 a settlement was proposed between the largest tobacco companies and the attorneys general representing 40 states. Because it contained clauses that imposed limitations on FDA authority and the civil justice system, Congressional legislation and Presidential approval were required in order to confer upon the settlement agreement the force of law.

Following the announcement of the settlement agreement, Senate Commerce Committee Chairman John McCain (R-Arizona) and three co-sponsors introduced the first tobacco settlement legislation bill. The National Tobacco Policy and Youth Smoking Reduction Act (S.1415, otherwise known as the McCain Committee bill), would have required the tobacco industry to pay \$516 billion over 25 years, raised cigarette taxes by \$1.10 per pack over five years, preserved FDA jurisdiction over tobacco, and curtailed cigarette promotion. Notably, the McCain Committee bill did not completely immunize the tobacco industry from future lawsuits. In April 1998, accusing Congress of deviating from the original terms of the June 1997 agreement, RJR-Nabisco CEO Steven Goldstone announced that his company was withdrawing its support from the Congressional process of drafting legislation. The other tobacco executives made similar announcements, and the McCain Committee bill died shortly afterward.

The tobacco companies immediately began trying to renegotiate a settlement agreement, and on November 23, 1998 the Master Settlement Agreement (MSA) was signed. (Meanwhile, from August 1997 to May 1998, four states—Mississippi, Florida, Texas and Minnesota—reached separate settlement agreements.) The MSA did not require approval by Congress because it excluded provisions dealing with federal jurisdiction over the nicotine contained in tobacco products.

One of the conditions of the settlement, as noted in Section VI of the MSA, was that the participating tobacco firms make payments towards a “charitable foundation, trust or similar organization and/or to a program to be operated within the Foundation”⁷⁷—and the American Legacy Foundation (ALF) was born. The ALF operates in three core areas, including evaluation and applied research, strengthening state and local tobacco control efforts through grantmaking and technical assistance, and sustained counter-advertising and public education campaigns at the national level.

The MSA reached final approval status in November 1999, and payments will begin to move from interest-bearing escrow accounts to state treasuries, pending court approval in the respective jurisdictions. The states expect to receive a total of \$8.7 billion over the next two years. Anticipation of the windfall has prompted budget battles in many state legislatures, as the MSA does not specify how the money must be spent. Michigan, for example, has set aside 75 percent of its money for a new college scholarship fund. Most of North Dakota’s payments have been used for water projects. A recent analysis of state budget and tobacco control bills revealed that only 15 of the 46 signing states have set aside money for tobacco control programs; furthermore, only six cents of every dollar received have been committed to health care.⁷⁸

Who are the major cigarette makers?

Philip Morris Companies, Inc., is a holding company consisting of the principal wholly-owned subsidiaries Philip Morris, Inc., Philip Morris International, Inc. (“PMI”), Kraft Foods, Inc., and Miller Brewing Company. The cigarette arms of Philip Morris push cigarettes in 180 markets worldwide, making Philip Morris the world’s largest cigarette maker with a 45 percent market share in the U.S. and a 17 percent market share worldwide. Philip Morris’s major premium brands are Marlboro

(the world's top cigarette, with a 35 percent market share in the U.S. and six percent market share worldwide), Virginia Slims, Merit, Alpine and Parliament. Its principal discount brands are Basic and Cambridge. PMI also markets L&M, Bondstreet, Benson & Hedges, Chesterfield, Petra, Multifilter, Longbeach, Caro, Next, Klubowe, Diana and Lark internationally. PMI has a cigarette market share of at least 15 percent in more than 40 countries. As of 1998, this firm employed approximately 144,000 people worldwide.

British American Tobacco p.l.c. (BAT), spun off from B.A.T. Industries p.l.c. in 1998, is the London-based owner of U.S. subsidiary Brown & Williamson Tobacco. It retains 69 tobacco-related subsidiaries in 56 countries, along with five associated organizations in which the company owns less than a 50 percent share. BAT owns 42 percent of Canadian affiliate Imasco Ltd. BAT's June 1999 US\$8.2 billion acquisition of Rothmans International NV gave it a 16 percent market share worldwide, second only to Philip Morris. Brown & Williamson has a 20 percent market share in the U.S. BAT is the producer of such brands as Kent, Benson & Hedges, State Express 555, John Player Gold Leaf, Pall Mall, Peter Stuyvesant, Rothmans and Dunhill, while Brown & Williamson produces GPC, Kool, Lucky Strike, Viceroy, Capri, Carlton, Misty and Tareyton. BAT employs more than 50,000 people.

Box 3: Major Cigarette Makers and Their Brands

The following table lists selected brands marketed by the major tobacco companies. Note that in some cases, two companies may market the same brand. For example Japan Tobacco, after purchasing RJR International, now markets Camel cigarettes globally.

Philip Morris, Inc.	British American Tobacco p.l.c.	Japan Tobacco, Inc.	R.J. Reynolds Tobacco Co.
Marlboro	Benson & Hedges	Mild Seven	Camel
Virginia Slims	Kent	Winston	Doral
Merit	Rothmans	Camel	Winston
Benson & Hedges	John Player Gold Leaf	Caster	Salem
Parliament	Pall Mall	Doral	Vantage
Alpine	Dunhill	Salem	More
L&M	State Express 555	Seven Stars	Now
Bondstreet	GPC	Valient	Century
Chesterfield	Kool	Cabin	Sterling
Lark	Lucky Strike	Frontier	Magna
Cambridge	Viceroy	Hope	Monarch
Basic	Capri	Hi-Lite	Best Value

Formerly a monopoly owned by the Japanese government, **Japan Tobacco** was privatized in 1985. In 1999 Japan Tobacco, Inc., purchased the international tobacco business of R.J. Reynolds International for US\$7.8 billion, making it the third largest global tobacco company, operating in 70 countries with a worldwide market share of eight percent. Japan Tobacco, still two-thirds government-owned, holds 75 percent of the Japanese domestic cigarette market, the world's third largest cigarette market after China and the U.S. The company markets 139 global cigarette brands, including three brands in the global top five (Mild Seven, Winston and Camel) and an additional four in the global top 20 (Caster, Doral, Salem and Seven Stars). Other brands include Valient, Cabin, Frontier, Hope and Hi-Lite. The company's non-tobacco business operations include agribusiness, engineer-

ing, pharmaceuticals, real estate and foods, although tobacco still accounts for approximately 90 percent of overall net sales (roughly US\$8.1 billion in 1997). Japan Tobacco's global tobacco-related work force totals approximately 35,000 people.

R.J. Reynolds Tobacco Co. was, until June 1999, a wholly-owned subsidiary of RJR-Nabisco Holdings Corp. A restructuring effort split RJR and Nabisco into two separately traded companies and sold RJR-Nabisco's international business to Japan Tobacco. RJR now maintains a 24 percent market share in the U.S., second only to Philip Morris's 45 percent. RJR sells four of the top 10 selling brands in the U.S.—Doral (#2 overall, #1 among “discount brands”), Camel (#4), Winston (#5) and Salem (#9). Other major domestic brands include Vantage, More, Now, Century, Sterling and Magna. Monarch, and Best Value are among its discount brands. RJR currently employs 8,800 people.

What are the “secret industry documents?”

During the *discovery* phase of the U.S. state lawsuits, lawyers were able to access confidential documents circulated among tobacco executives, researchers and marketers. Despite industry claims of attorney-client privilege, the Minnesota lawyers were able to obtain these documents and subsequently posted to the World Wide Web the documents used as exhibits in litigation. The Master Settlement Agreement saw the release of more industry documents to the public. An excellent analysis of these document repositories has been published in a special edition of the *Multinational Monitor* magazine.⁷⁹

Where can I find these industry documents online?

- **The U.S. Centers for Disease Control and Prevention Tobacco Industry Documents:**

This CDC gateway is the implementation of the President's July 1998 Executive Memorandum to increase access to the tobacco industry documents and make them more easily available via the Internet. There are links to a number of the other Web sites, along with descriptors and usage guides.

<http://www.cdc.gov/tobacco/industrydocs/index.htm>

- **On-line Tobacco Document Archives:**

The documents from four tobacco companies and two organizations were subpoenaed and made publicly available. The web page links to the six document archives maintained by each of the previously mentioned companies and organizations.

<http://www.tobaccoarchives.com/>

- **Blue Cross and Blue Shield of Minnesota Tobacco Web Site:**

During the course of the Minnesota trial, documents entered as evidence in the trial were posted on the World Wide Web page beginning February 12, 1998. The documents are sorted by the order in which they were entered as evidence during the trial. There is also a search engine and a “quick view” of documents arranged by subject.

<http://www.mnbluecrosstobacco.com/toblit/trialnews/docs/>

- **U.S. House of Representatives Committee on Commerce Subpoenaed Tobacco Documents:**

The documents from four tobacco companies and two organizations were subpoenaed and made publicly available on the World Wide Web page. The Commerce Committee site does not offer a search engine, but many of these documents are searchable through the Smokescreen Action Network's valuable online databases (see “Tobacco Documents Online,” below).

<http://www.house.gov/commerce/TobaccoDocs/documents.html>

Are the industry documents available anywhere else?

The online document archives maintained by the tobacco companies can be bewildering, and locating usable information is difficult. Michael Ciresi, a Minneapolis attorney who argued Minnesota's suit against the tobacco industry, has likened the industry's disclosures to "throwing a big pile of hay at you and telling you there's a needle in there."⁸⁰ The tobacco companies have sought to keep their own detailed indices private, for the indices could potentially act as a table of contents for people sorting through the millions of pages of documents. Several public interest organizations have catalogued portions of these archives, presenting them in a more readily searchable format. Thus, these sub-collections provide substantial value-added. A few of these efforts are cited below:

- **Tobacco Documents Online:**

The Smokescreen Action Network downloaded approximately 100,000 of the documents originally posted on the Commerce Committee site and ran them through OCR so that text searches could be performed. A number of private sub-collections of industry documents are also indexed on this site, including the Anne Landman Collection, the Massachusetts Tobacco Control Program Collection, the Roswell Park Cancer Institute Collection and others.

<http://www.tobaccodocuments.org>

- **The Cigarette Papers:**

Written by Stanton A. Glantz and colleagues, *The Cigarette Papers* (University of California Press, 1996) presents the UCSF researchers' complete analysis of several thousand pages of documents from the Brown & Williamson Tobacco Corporation. The documents and the book are available to the public for viewing online, and the UCSF library also has a CD-ROM version of the documents for sale. The online database is indexed by subject.

<http://galen.library.ucsf.edu/tobacco/cigpapers/book/contents.html>

Is there any academic research published on this subject?

There is certainly a great deal of academic research on tobacco use prevention and control. The U.S. National Library of Medicine's MEDLINE database (<http://igm.nlm.nih.gov>) is always a good starting point to locate journal articles. Selected publications referenced in this report are highlighted below.

Clinical guidelines on smoking cessation and implications for your future medical practice:

Fiore MC, Bailey WC, Cohen SJ, et al. *Smoking cessation*. Clinical Practice Guideline No. 18. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research. AHCPR Publication No. 96-0692, April 1996.

Tobacco and the clinician: interventions for medical and dental practice. *Smoking and Tobacco Control Monograph No. 5*. National Cancer Institute, National Institutes of Health, 1999.

Books and reports on the international aspects of tobacco control:

Frankel G. U.S. aided cigarette firms in conquests across Asia; aggressive strategy forced open lucrative markets. *Washington Post*, pA01 (four-part series), November 17, 1996.

Hammond R. *Addicted to profit: Big Tobacco's expanding global reach*. Washington, DC: Essential Action, 1998.

INFACT. *Global aggression: the case for world standards and bold U.S. action challenging Philip Morris and RJR-Nabisco*. New York: Apex Press, 1998.

The World Bank. Jha P, Chaloupka FJ. *Development in practice: Curbing the epidemic: governments and the economics of tobacco control*. A World Bank Publication. USA, May 1999.

World Health Organization. *The World Health Report 1999: Making a difference*. Geneva, Switzerland: WHO, 1999.

Investigative reports on tobacco industry strategies:

Glantz SA, Slade J, Bero LA, Hanauer P, Barnes DE. *The cigarette papers*. San Francisco: University of California Press, 1996.

Kluger R. *Ashes to ashes: America's hundred-year cigarette war, the public health, and the unabashed triumph of Philip Morris*. Vintage Books, 1996.

Multinational Monitor. Meet the tobacco papers: where the tobacco papers come from, how to locate them, and what's missing. Special issue – The tobacco papers: the greatest cache of corporate secrets ever made public. *Multinational Monitor* 1998;19(7):9-32.

Academic journal articles from the tobacco control literature:

Aftab M, Kolben D, Lurie P. International cigarette labeling practices. *Tob Control* 1999;8:368-72.

Doll R, Peto R. Mortality in relation to smoking: 20 years' observations on male British doctors. *BMJ* 1976 Dec 25;2(6051):1525-36.

Doll R, Peto R, Wheatley K, Gray R, Sutherland I. Mortality in relation to smoking: 40 years' observations on male British doctors. *BMJ* 1994 Oct 8;309(6959):901-11.

Fischer PM, Schwartz MP, Richards JW Jr, Goldstein AO, Rojas TH. Brand logo recognition by children aged 3 to 6 years. Mickey Mouse and Old Joe the Camel. *JAMA*. 1991 Dec 11;266(22):3145-8.

King C 3rd, Siegel M, Celebucki C, Connolly GN. Adolescent exposure to cigarette advertising in magazines: an evaluation of brand-specific advertising in relation to youth readership. *JAMA* 1998;279(7):516-20.

Warner KE, Hodgson TA, Carroll CE. Medical costs of smoking in the United States: estimates, their validity, and their implications. *Tob Control* 1999;8:290-300.

Other Internet Resources

The Internet houses a wealth of information in addition to those already listed. Over the past few years, the amount of information available to tobacco-control advocates worldwide has increased dramatically. Selected organizations as well as resources from their Web pages are highlighted below.

- **Action on Smoking and Health (United Kingdom):**

ASH-UK is a London-based non-governmental organization providing information on all aspects of tobacco. ASH-UK's extensive online library provides guides on smoke-free pubs, restaurants and hotels; information on smoking cessation including foreign language help lines; materials for use in schools; and tips on advocating for and implementing a smoke-free workplace policy. The Web page offers a comprehensive array of resources on global tobacco control, including policy work, the publication *Tobacco Explained*, reports on covert industry activity and fact sheets.

<http://www.ash.org.uk/>

- **American Cancer Society:**

The Tobacco Control section of their Web page houses numerous fact sheets on health issues, quitting tips, smoking legislation and smoking-related cancers.

<http://www.cancer.org/tobacco/index.html>

- **American Legacy Foundation:**

Created as a result of the Master Settlement Agreement, the ALF will direct significant resources toward research, grant-making, technical assistance and national public education campaigns in the area of tobacco use prevention and control. The Web page contains information on the "Truth" counter-advertising campaign and will soon provide a clearinghouse of information for ongoing research.

<http://www.americanlegacy.org/>

- **American Lung Association:**

The Tobacco Control section of their Web page contains information on tobacco control among targeted U.S. minority populations, tips on quitting and fact sheets.

<http://www.lungusa.org/tobacco/>

- **Americans for Non-Smokers' Rights:**

ANR has promoted the enactment of more than 1,000 city and county ordinances across the United States since the early 1980s. Accordingly, their Web page features toolkits on how to advocate for smoke-free areas and confront those who violate smoke-free ordinances; tip sheets on how to meet with and testify before elected officials, write letters and speak in public; and model smoke-free ordinances.

<http://www.no-smoke.org/>

- **Campaign for Tobacco-Free Kids:**

This campaign focuses on protecting America's youth from nicotine addiction and ETS exposure. The Web page features a number of resources, including overviews of the global tobacco problem, a series of fact sheets, and a "top stories" section with links to key news stories.

<http://www.tobaccofreekids.org/>

- **Centers for Disease Control and Prevention:**

The CDC Tobacco Information and Prevention Source (TIPS) page provides overviews on various issues, links to related articles in the *Morbidity and Mortality Weekly Report* and other research

data and reports. Notably, the CDC offers a weekly “new citations” service that tracks new tobacco-related research publications. The State Tobacco Activities Tracking and Evaluation (STATE) System is an electronic data warehouse containing up-to-date and historical state-level data on tobacco use prevention and control. The Smoking and Health Database contains abstracts of journal articles, books and book chapters, dissertations, reports, conference proceedings and conference papers, government documents, policy or legal documents, editorials, letters and comments on articles.

<http://www.cdc.gov/tobacco/tobacco.htm>

- **Doctors Ought to Care:**

DOC’s mission has remained unchanged since its inception in 1977: To educate the public in humorous and refreshing ways about the promotion of tobacco and alcohol products to adolescents and the major preventable causes of poor health and high medical costs attributable to their use. In 1994 the DOC International Health Education and Research Foundation was established to support their resource center, an invaluable collection of print, audio, video, artifacts and other materials documenting the history of tobacco use, and the influence of tobacco advertising on society.

<http://www.bcm.tmc.edu/doc/>

- **Essential Action:**

This Ralph Nader-affiliated organization was created to alert activists to current international campaigns, including global tobacco control. The Web page features a number of public interest letters written by Ralph Nader and Robert Weissman, background information on the tobacco settlement’s international issues, and links to special tobacco-focus issues of the *Multinational Monitor*. There is also a special online version of Ross Hammond’s book *Addicted to Profit: Big Tobacco’s Expanding Global Reach* (Essential Action, 1998); this book provides an excellent overview of the tobacco industry’s activities abroad.

<http://www.essentialaction.org/>

- **GLOBALink:**

GLOBALink is the Internet and new-technologies unit of the Geneva, Switzerland-based Union Internationale Contre le Cancer (UICC). Membership in GLOBALink is by application/referral only. The Web page provides invaluable resources for tobacco control advocates worldwide, including news bulletins, searchable research databases, Web hosting for cancer prevention-related activities, and papers and other documents published by tobacco control organizations worldwide.

<http://www.globalink.org/gt/>

- **Smokescreen Action Network:**

A number of informational listservs are operated through this Web page. Some of the listservs include: Anne Landman’s Daily Document (once-a-day mailing about a specific industry document), Secondhand Smoke Forum (forum for discussing ETS and other clean-air issues), Stan Glantz Announcement List (periodic notes from activist-researcher Stan Glantz), and Cigar Talk (discussion about cigars).

<http://www.smokescreen.org/>

- **World Health Organization:**

The WHO Tobacco-Free Initiative contains a great deal of information on the international aspects of tobacco control, including progress reports on the Framework Convention on Tobacco Control, speeches made by the Director-General, international conference updates and other documents. The World Bank Report, *Curbing the Epidemic*, is also available for download here.

<http://www.who.int/toh/>

Glossary of Organizations

- **World Bank:**

Founded in 1944, the World Bank Group is the world's largest source of development assistance, providing nearly \$30 billion in loans annually to its client countries. It consists of five closely related institutions: the International Bank for Reconstruction & Development, which provides loans and development assistance to middle-income countries and creditworthy poorer countries; the International Finance Corporation, which finances private sector investments and provides technical assistance and advice to governments and businesses in developing countries; the Multilateral Investment Guarantee Agency; the International Development Association, which provides interest-free loans and other services to the poorest countries; and the International Center for Settlement of Investment Disputes.

<http://www.worldbank.org/>

- **World Health Organization:**

According to its mission statement, the objective of WHO is "the attainment by all peoples of the highest possible level of health." To this end, WHO coordinates international health work, promotes technical cooperation, provides assistance to governments on strengthening health services and engages in a wide range of other functions.

<http://www.who.org/>

- **U.S. Agency for Health Care Policy and Research:**

AHCPR, the health services research arm of the U.S. Department of Health and Human Services, was renamed the U.S. Agency for Healthcare Research and Quality (AHRQ) as a result of the Healthcare Research and Quality of Act of 1999. The Act reaffirmed AHRQ's status as a scientific research agency and established AHRQ as the lead Federal agency charged with supporting research designed to improve quality of health care, reduce its cost, improve patient safety, decrease medical errors and broaden access to essential services.

<http://www.ahrq.gov/>

- **U.S. Federal Trade Commission:**

The FTC enforces a variety of federal antitrust and consumer protection laws to achieve the end of ensuring that markets function competitively and efficiently, free of undue restrictions and deceptive practices.

<http://www.ftc.gov/>

- **U.S. National Cancer Institute:**

The NCI is one of the 25 institutes and centers that comprise the National Institutes of Health, one of the eight agencies that comprise the Public Health Services in the U.S. Department of Health and Human Services. NCI coordinates the National Cancer Program, which conducts and supports research, training, health information dissemination and other programs with respect to the cause, diagnosis, prevention and treatment of cancer rehabilitation from cancer, and the continuing care of cancer patients and the families of cancer patients.

<http://www.nci.nih.gov/>

- **U.S. Trade Representative:**

The Office of the U.S. Trade Representative is responsible for developing and coordinating U.S. policies on international trade, commodities and direct investment. The USTR is a Cabinet member who acts as the principal trade advisor, negotiator and spokesperson for the President on trade and related investment matters.

<http://www.ustr.gov/>

Notes

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