



*Position Paper on
Spending the Tobacco
Settlement Funds
in Arkansas*

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**The Health Policy Board
of the Arkansas Center for Health Improvement**

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**The mission of the
Arkansas Center for Health Improvement
is to improve the health of Arkansans
through policy research, professional
education, program development,
and public advocacy.**

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Executive Summary

Arkansas anticipates receiving \$20 million in 1999 from the recent nationwide tobacco settlement. Starting in 2000, the state will receive \$53 million annually for the next 25 years. This settlement will limit future efforts to collect monetary compensation for damage caused by tobacco through illness, death, and lost productivity. States may use this money for any purpose they choose.

The Arkansas Center for Health Improvement (ACHI) was established as an independent, nonpartisan organization by the University of Arkansas for Medical Sciences and the Arkansas Department of Health. ACHI is advised by a Health Policy Board, which has representatives with diverse experiences including consumer representatives, business and community leaders, educators, health care system executives, and public health care professionals. ACHI's Health Policy Board has developed four principles that it believes should guide the Arkansas Legislators and Governor in appropriating this money.

- 1. All funds should be used to improve and optimize the health of Arkansans.**
- 2. Funds should be spent on long-term investments that improve the health of Arkansans.**
- 3. Future tobacco-related illness and health care costs in Arkansas should be minimized through this opportunity.**
- 4. Funds should be invested in solutions that work effectively and efficiently in Arkansas.**

Arkansans are among the least healthy people in the US, ranking last in the nation from 1994 through 1998 in terms of overall health and access to care according to *Health Care State Rankings 1998*. This ranking is based on many factors, including smoking rates, obesity, infant mortality, motor vehicle accidents, and death rates (which are 13% higher than the national average in Arkansas). However, many of the health problems of Arkansans are avoidable. One-half of all deaths are premature, with unhealthy behaviors accounting for 25% of all deaths. Tobacco use is a major factor in these behavior-related deaths—it is linked to cancer, heart disease, stroke, chronic lung disease, and low birth weight infants. Nationally, tobacco use contributes to more than 5 million years of potential life lost due to illnesses and premature deaths each year.

The cost of tobacco use is high—Arkansas spends ~\$256 million yearly in direct medical costs for tobacco-related health care and untold amounts in indirect costs, such as lost productivity. Even if all tobacco taxes (\$98 million/year) and tobacco settlement money (\$53 million/year) are applied toward health care for those suffering from the effects of tobacco use, an additional \$100 million/year will be needed to pay for these health costs. Efforts must be made now to curb the future costs associated with tobacco use. To reverse this trend, improve health and productivity, and manage future health care costs, state policymakers must ensure that appropriate steps are taken to prevent future disease and promote good health.

Investments in expanded health care coverage, professional and public education, targeted research, and successful disease prevention and health promotion strategies can change the course of Arkansans' health. The principles promoted by the Arkansas Center for Health Improvement are intended to provide guidance to Arkansas Legislators and the Governor in seizing this critical opportunity for optimizing the future health and productivity of Arkansans.

Introduction

Arkansas anticipates receiving \$20 million this year as part of a nationwide agreement with tobacco companies. Starting in 2000, the state will receive more than \$53 million annually for the next 25 years.¹ The costs of tobacco use in both lives and dollars is substantial and remains unchecked.

In light of the opportunity represented by the tobacco settlement money, the Arkansas Center for Health Improvement proposes four key principles to guide decisions and allocation of this money.

- 1. All funds should be used to improve and optimize the health of Arkansans.**
- 2. Funds should be spent on long-term investments that improve the health of Arkansans.**
- 3. Future tobacco-related illness and health care costs in Arkansas should be minimized through this opportunity.**
- 4. Funds should be invested in solutions that work effectively and efficiently in Arkansas.**

Investments in expanded health care coverage, professional and public education, targeted research, and successful disease prevention and health promotion strategies can change the course of Arkansans' health. The principles suggested by the Arkansas Center for Health Improvement are intended to provide guidance to Arkansas Legislators and the Governor in seizing this critical opportunity for optimizing the future health and productivity of Arkansans.

Health Status of Arkansans

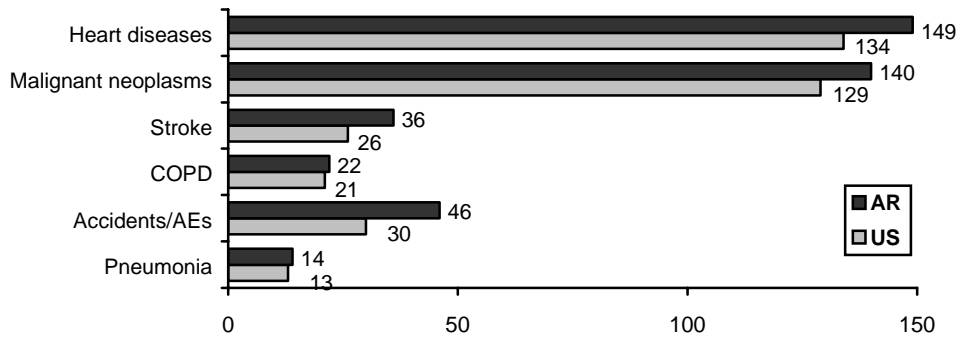
Despite the high quality of medical care available in Arkansas and favorable trends in several health indicators, the state continues to face significant health problems. Arkansans, as a whole, lack good health. The state ranked last in the nation for the past 5 years in terms of overall health and access to care, according to *Health Care State Rankings*.² Another comparative health index, the *ReliaStar State Health Rankings*, placed the health of Arkansans 45th in the nation.³ A major contributing factor to these ratings is the state's death rate, which is 13% higher than the national age-adjusted rate (559.5 deaths vs. 493.6 deaths per 100,000 individuals).⁴

Illness and Death

Overall, Arkansans are sicker and die earlier than Americans elsewhere. Among common clinical conditions, Arkansas ranks 1st nationally in the percent of women with obesity-related diabetes,⁵ 2nd for lung cancer, 4th for ischemic heart disease, and 5th for all types of cancer.⁶ A greater percent of people in Arkansas died of heart disease, stroke, cancer, lung disease, and accidents than in the nation as a whole (Figure 1).⁷

The average age-adjusted cancer death rate in Arkansas is also significantly higher than the national average, giving the state the 15th highest cancer death rate in the US.⁸ Men in the state have the 11th highest cancer death rate at 239.6 deaths per 100,000 men annually (US men, 219.1 per 100,000).⁹ Lung cancer and other lung diseases, in particular, are devastating to the citizens of Arkansas, which has the 2nd highest, age-adjusted, national death rate from lung diseases (AR, 87.8; US, 72.5 per 100,000).¹⁰

**Figure 1:
Age-Adjusted Mortality Rates for the 5 Leading Causes of Death in Arkansas
(per 100,000 population)**



COPD = chronic obstructive pulmonary diseases and allied conditions. Source: 1996 Mortality Statistics. Arkansas Department of Health.

Children, especially infants, face a greater risk of death in Arkansas than in the country as a whole, with an infant mortality rate that is 15% higher than the national average—the 10th highest in the nation (9.3 versus 7.2 deaths per 1000 live births). For African-American babies in the state, the infant mortality rate is even higher, at 13.7 per 1,000 live births.¹¹

Health Consequences of Tobacco Use

Tobacco use causes more deaths (400,000 or 19% of all deaths) than any other preventable factor, including poor diet, lack of physical activity, alcohol abuse, infections including AIDS and influenza viruses, toxic agents, injuries due to guns, motor vehicle accidents, illicit drug use, and lack of health care access. Because people die prematurely from avoidable illnesses, each year more than 5 million years of potential life are lost due to tobacco use,¹² via its contributing role in heart disease, cancer, stroke, high blood pressure, lung diseases, and low birth weight infants.¹³

Tobacco use during childhood and adolescence can have particularly devastating and long-term health consequences.¹⁴ Cigarette smoking during childhood and adolescence produces significant health problems among young people, including cough and phlegm production, an increased number and severity of respiratory illnesses, decreased physical fitness, and potential retardation in the rate of lung growth and the level of maximum lung function. In addition to cigarette smoking, smokeless tobacco use by adolescents is

associated with earlier indicators of tooth and gum decay and with pre-cancerous lesions in the mouth.

Among addictive behaviors, tobacco use is the one most likely to become established during adolescence. People who begin to smoke at an early age are more likely to develop severe nicotine addiction than those who start at a later age. Approximately 80% of adult smokers started smoking before the age of 18. Every day in the US, nearly 3,000 young people under the age of 18 become smokers.¹⁵

Another significant cause of poor health is environmental tobacco smoke, or “second-hand smoke”, which includes mainstream smoke (that exhaled by a smoker) and sidestream smoke (from the burning end of the cigarette). Second-hand smoke is classified as a Group A carcinogen—a substance with no safe level of exposure and one that causes cancer in humans.¹⁶ Evidence is growing that second-hand smoke substantively affects the health of nonsmokers and has high costs to industry. In children, exposure to second-hand smoke is estimated to cause 150,000–300,000 respiratory infections each year, leading to 7,500–15,000 hospitalizations.¹⁴

Cancer is closely linked with tobacco use. Cancer incidence and death rates are higher in Arkansas than nationally. Lung cancer, which has one of the poorest prognoses of all cancers, is the leading cause of death from cancer in both men (32% of cancer deaths) and women (25% of cancer deaths) in the US. In Arkansas, 45% of all cancer deaths in men and 29% of all cancer deaths in women are caused by lung cancer. Importantly, tobacco is associated with 87% of all cases of cancer of the lung, trachea, and bronchus. Other cancers associated with smoking include cancer of the mouth, throat, and esophagus, larynx, pancreas, bladder, and cervix.¹⁷

Tobacco Use in Arkansas

Despite widespread publicity about the dangers of smoking and its link to adverse health outcomes and premature death, use of tobacco is pervasive and growing in Arkansas.

- Arkansas has the 3rd highest smoking rate in the nation with more than 1 in 4 adults in the state smoking.¹⁸
- Of reproductive age women, 27% of Arkansans smoke; this habit will have a direct affect on the health of their newborns including low birth weight and poor pregnancy outcomes.
- Each hour, one new Arkansan under the age of 18 becomes a regular smoker.
- Almost 3 out of 4 adolescents (73%) have tried cigarettes by the time they reach 9th grade; this experimentation has become a habit for nearly half of 12th graders with 49% smoking at least once a month.¹⁹
- Approximately 178,000 of the state’s children and adolescents are exposed to second-hand smoke in their homes.

- Smokeless tobacco use is reported among 14% of Arkansas youths in grades 9–12.¹⁹
- This year, 2,200 Arkansans will be diagnosed with lung cancer and 2000 will die of lung cancer; almost all of these deaths will be related to smoking cigarettes.^{8,20}
- Current smokers are twice as likely to lack health insurance compared to non-smokers.²¹

Costs of Poor Health and Tobacco Use

Costs associated with avoidable illnesses and lost productivity are immeasurable. Expansion opportunities for existing industry and recruitment efforts for new businesses are impaired by the lack of a healthy workforce. Tobacco use is a major cause of lost productivity due to illness. In addition, smoking in the workplace increases property maintenance and cleaning costs by approximately \$500 per smoker per year,²² and results in lost-productivity costs among non-smokers as well.²³

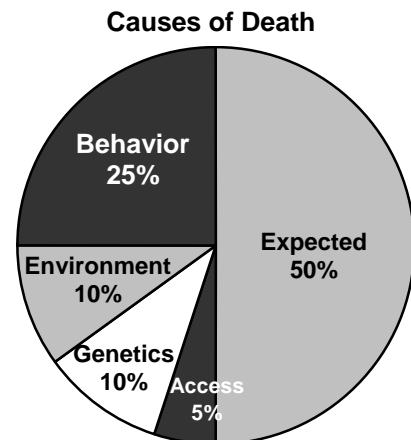
Out of every 5 deaths, 1 is attributable to tobacco use. Arkansas spends approximately \$256 million in direct medical costs for tobacco-related health care.²⁴ Even with the \$98 million annual tax revenue on the sale of tobacco products²⁵ and the maximum \$53 million annual payments by the tobacco companies, the state will continue to lose more than \$100 million each year paying for health care because of tobacco use. To reverse this trend, to improve the health and productivity of Arkansans, and to effectively manage future health care costs, state policymakers must ensure that appropriate steps are taken.

Due to the health implications described above, the Arkansas Center for Health Improvement's Health Policy Board has developed four principles that it believes should guide the Arkansas Legislators and Governor in appropriating this money.

Principle 1: All funds should be used to improve and optimize the health of Arkansans.

Preventable Illness and Premature Death

Many factors contribute to preventable illness and premature death in the United States. The single largest contributing cause is individual behavior—everyday actions determine present and future health. Nationally, more than 2¼ million people die each year.²⁶ One-half of these deaths are premature and thus preventable. Unhealthy and modifiable behaviors cause 25% of the



deaths each year (>550,000 nationally).²⁷ While some of the causes of poor health are beyond the reach of the health care system, the importance of modifying behaviors and improving understanding through clinical interactions is critically important. These opportunities to implement health improvement strategies, which educate and encourage both individuals and health care providers to take action, offer tangible promise to change the health status of Arkansans. The effects of such efforts on individuals, the economy, and communities offer great potential for this state.

Expanded Health Care Coverage for the Medically Indigent

A major contention of the State Attorneys General in the tobacco lawsuits that resulted in the nationwide settlement was that states had substantial costs for uncompensated health care caused by tobacco-related illnesses. This occurred generally through two mechanisms: the states' support of Medicaid and the public costs of providing care for those who lack insurance or who are underinsured. These medically indigent individuals create substantial and often undocumented costs to the health care system that is borne by the public.

In 1996, Arkansas had the 5th highest rate in the US of individuals with no insurance—22% of Arkansans did not have any source of insurance coverage. Private employer-paid insurance covered 36% of Arkansans with government insurance (Medicare, Medicaid, and state-employee/teacher program) covering an additional 35%. More than 7% of Arkansans purchased health insurance independently.²⁸ Previous studies have shown that insurance coverage is critical for establishing a medical home that results in appropriate treatment for most conditions. In addition, timely and appropriate use of clinical preventive services is dependent upon first dollar coverage for key services.

Arkansas recognized the importance of insurance to health and, through the ARKids First program established in 1997, the state has selectively expanded the Medicaid program to cover children of parents making between 100% and 200% of the federal poverty level. Through this nationally recognized program, more than 35,000 children have enrolled and now have a medical home with insurance coverage for needed preventive services and care, should illness strike.²⁹

While insurance coverage for children has expanded, welfare reform passed in 1997 threatens to disrupt existing sources of care for Arkansans. Arkansas has witnessed a drop in welfare caseloads as a result of a strong state economy and welfare reform—20,943 fewer welfare recipients representing a 39% reduction since passage of welfare reform in June 1997 through October 1998. However, because Arkansas provides only 12 months of transitional Medicaid benefits and because many entry-level jobs do not offer health insurance, the loss of health care benefits is a real threat for former welfare recipients—there are 44.7% (6,580) fewer adults on transitional Medicaid and

36.6% (14,363) fewer children on transitional Medicaid since the start of welfare reform in June 1997.³⁰

Recent studies in other states have found that families making the transition from welfare to work are at increased risk of being uninsured. In Indiana, two-thirds of the parents participating in the state's welfare program were working; of those parents, almost half were without health insurance coverage. Similarly, the South Carolina Department of Social Services found that of adults who left the welfare rolls and established employment, only about half were insured. If we are to successfully achieve goals for moving individuals and families from welfare to work, Arkansas must eliminate barriers to successful independence.³¹

Several options are available to states to expand health care coverage. These include:

- Medicaid demonstration waivers,
- direct support for uncompensated care for the medically indigent,
- state-funded insurance premium assistance programs, or
- state children's health insurance programs.

Individual and combined options provide optimal state flexibility to allow tailored development of needed programs.

Older adults also face problems paying for needed medical services. While Medicare provides primary coverage to most Arkansans over 65 years of age, the lack of coverage for pharmaceuticals and ancillary services continues to force elderly Arkansans to under-utilize effective and prescribed treatments. Thus, available access and appropriate diagnosis is thwarted by treatment failures due to lack of coverage for appropriate therapies. Options exist to establish low-cost prescription services for target populations.

Targeting support for these important issues can minimize the deleterious effect lack of insurance has on Arkansans. Access to appropriate care and use of important services will improve the health of Arkansans.

Principle 2: Funds should be spent on long-term investments that improve the health of Arkansans.

Opportunity for Professional Education

Clinicians and health care professionals do not consistently assess whether their patients use tobacco, nor do they offer smoking cessation advice and treatment to smokers at office visits. Evidence shows that 70% of US smokers see their physician each year,³² and 60% of the US population aged 5 years and older is seen by a dentist,³³ giving physicians and dentists considerable access to smokers. If only half of all the US physicians and dentists gave brief advice to their patients and 10% of them were successful in quitting, there would be nearly 2 million new nonsmokers in the US each year.³⁴

Inadequate training, lack of time and lack of reimbursement for services have made it difficult for physicians and other health care professionals to provide adequate smoking cessation counseling and treatment. Incorporating prevention education in professional training is required to stimulate clinicians to support patients' efforts to quit smoking and to advocate for changes that support disease prevention and health promotion. Practicing clinicians also require continuing education to raise awareness and improve use of interventions that successfully assist patients in avoiding tobacco-related illnesses.

Contribution of Research

Since the landmark article in 1950 linking tobacco as a contributing factor in lung cancer,³⁵ the research community has increased the understanding of how tobacco causes illness and provided tools to both prevent and treat conditions associated with tobacco use.

Tobacco is one of the major cancer-causing agents in humans, causing an estimated 148,000 deaths among smokers annually due to smoking-related cancers.³⁶ The majority of all cancers of the lung, trachea, bronchus, larynx, pharynx, oral cavity, and esophagus are attributable to the use of smoked or smokeless tobacco.^{37,38} Smoking also accounts for a significant but smaller proportion of cancers of the pancreas,^{39,40,41,42} kidney, bladder,^{39,43} and cervix.^{39,44,45,46}

Smoking also promotes hardening of the arteries and is a leading risk factor for heart attack and disease, stroke, and peripheral vascular disease.^{37,39} It is responsible for about 100,000 deaths from heart disease and 23,000 deaths due to stroke each year.⁴⁷ Smoking is an important risk factor for respiratory illnesses, causing 85,000 deaths per year from lung diseases such as chronic obstructive pulmonary disease and pneumonia.^{39,47}

The nicotine in tobacco is an addictive drug, and the pharmacologic and behavioral processes that determine nicotine addiction are similar to those that determine addiction to drugs such as heroin and cocaine.^{48,49}

Smoking affects the health of nonsmokers as well. Smoking during pregnancy causes about 5–6% of miscarriages and newborn deaths, 17–26% of low birth weight babies, and 7–10% of premature deliveries,^{37,39} and it also increases the risk of fetal growth retardation and is associated with congenital birth defects.⁵⁰ Passive smoking (or environmental tobacco smoke) increases the risk of lung cancer in nonsmokers,^{51,52} causing approximately 3,000 lung cancer deaths each year.⁴ Passive smoking has also been associated with an increased risk of sudden infant death syndrome.^{53,54,55}

The research community is rapidly contributing to our ability to assist smokers who desire to quit. A number of clinical trials have demonstrated the effectiveness of certain forms of counseling and pharmacological therapies in changing the smoking behavior of patients.^{56,57,58} For smokers who

successfully quit, rapid benefits in decreasing the risk of heart attacks, lung cancer, and stroke have been demonstrated.⁵⁹

Continued advances in our knowledge of tobacco's affect on health and improved tools to assist in personal behavior changes will optimize our ability to prevent future tobacco-related illness. The direct application of this knowledge will affect the major causes of illness and death for our state and improve the health of Arkansans.

Principle 3: Future tobacco-related illness and health care costs in Arkansas should be minimized through this opportunity.

To create long-term changes in the health of Arkansans, policies, programs, and services that encourage people to adopt healthier behaviors must be identified, implemented, and supported. Because the tobacco settlement funds are a direct result of tobacco use, prevention of future tobacco-related illness and health care costs should be given a priority.

Disease Prevention and Health Promotion

Clinicians have always intuitively understood the value of prevention. Faced daily with the difficult and often unsuccessful task of treating advanced stages of disease, primary care providers have long sought the opportunity to intervene early in the course of disease or even before disease develops. The benefits of incorporating prevention into medical practice have become increasingly apparent over the past 30–40 years. Previously common and debilitating conditions have substantially declined in incidence after the introduction of effective clinical preventive services. Infectious diseases such as polio, which once occurred in regular epidemic waves (>18,300 cases in 1954), have become rare in the US as a result of childhood immunization.⁶⁰ Preventive services for the early detection of disease are also associated with substantial reductions in illness and death. The age-adjusted death rate from stroke has decreased by more than 50% since 1972, a trend attributed in part to earlier detection and treatment of high blood pressure.^{61,62,63}

Although immunizations and screening tests remain important medical practices, the most promising role for prevention may lie in changing the personal health behaviors of patients long before clinical disease develops. The importance of prevention in clinical practice is supported by mounting evidence linking a handful of personal health behaviors to some of the leading causes of death in the US, such as heart disease, cancer, stroke, lung disease, unintentional and intentional injuries, and HIV infection.⁶⁴

Smoking alone contributes to 1 out of every 5 deaths in the US, including 150,000 deaths annually from cancer, 100,000 from heart disease, 23,000 from stroke, and 85,000 from lung diseases such as chronic obstructive pulmonary disease and pneumonia.⁶⁵ Through professional education, research, and

deployment, successful health promotion and disease prevention strategies are available to combat these findings.

While components of successful disease prevention and health promotion strategies exist both within traditional medical training and public health departments, successful deployment of a strategy to improve health requires combined resources and joint responsibility. Local, regional, and statewide monitoring of health status and utilization of services must be enhanced. Incorporation of disease prevention and health promotion must be incorporated into both professional and public educational curriculums. Finally, establishment of explicit expectations and responsibility to address preventable illness and disease is warranted.

Principle 4: Funds should be invested in solutions that work effectively and efficiently in Arkansas.

Eight major leverage points can be used to promote health and prevent diseases related to tobacco use:

1. increasing public education,
2. improving professional education,
3. increasing use of tobacco cessation programs by clinicians,
4. limiting youth access to tobacco,
5. use of school-based intervention programs,
6. restricting tobacco marketing and promotion,
7. advancing epidemiological and behavioral research, and
8. controlling environmental tobacco smoke.

Each of these requires support from individuals, clinicians, and state policy makers to successfully change the health-related habits of Arkansans.

Public Education and Media Campaigns

Public education and statewide health promotion campaigns are effective in reducing tobacco use.⁶⁶ These activities play a vital role in reducing the appeal of tobacco products by stopping children from developing a smoking habit, encouraging adults and youth to quit using tobacco, and changing the social context of tobacco use so that it is no longer a socially acceptable activity. While it is too early to evaluate the effects of many programs, statewide education and media campaigns:

- consistently show reductions in the proportions of students who begin regular smoking,^{67,68,69,70,71}
- are among the most cost-effective smoking prevention and cessation methods currently available in terms of cost per years of life gained,⁷²
- impact not only use, but also decrease illegal retail sales to minors (from 48% of retailers to 19% selling to minors);⁷³ and
- have lasting results in decreasing cigarette consumption for up to 15 years, after a combined education and media campaign.⁷⁴

Improving Professional Education

All major health care organizations and authorities recommend routine clinician counseling of adults, pregnant women, parents, and adolescents to avoid or discontinue smoking and use of smokeless tobacco.^{75,76,77,78,79,80,81,82,83,84,85,86,87,88} However, there is a lack of formal education for clinicians in the causative relationship between tobacco and common illnesses and training in successful methods of counseling. Incorporation of disease prevention and health promotion activities into the curriculum for clinicians, as well as continuing education opportunities for established clinicians, are needed to ensure adequate care is provided by health professionals.

Use of Tobacco Cessation Programs

When people stop using tobacco, many of the health risks associated with tobacco use are reversed, such as coronary artery disease, stroke, cancer, and ulcer. Pregnancy outcomes and lung function also improve after cessation.⁸⁹ Successful programs exist that assist individuals who currently use tobacco in quitting.

Tobacco-cessation counseling and treatment increase successful attempts to quit, when provided by clinicians and covered by insurance, as demonstrated by a large number of clinical trials.^{90,91,92} The intensity of the counseling also has an influence on successful smoking cessation. In a meta-analysis of 56 studies, cessation rates were 10.7% for those receiving <3 minutes of counseling, 12.1% for those receiving 3–10 minutes of counseling, and 18.7% for those receiving >10 minutes of counseling.⁹³

Counseling is especially effective for smokers at special risk, including those who are pregnant and those who have ischemic heart disease (15% and 21% cessation rates, respectively).^{93,94} A limited number of controlled trials have suggested that counseling is also effective for smokeless tobacco cessation.^{95,96,97,98} Tobacco-cessation interventions are more effective when implemented concurrently with pharmacologic therapy—nicotine replacement or other medications.^{56,93,99,100,101}

Limiting Youth Access to Tobacco

Enforcing restrictions on youth access to tobacco provides a major opportunity to prevent children and adolescents from starting to use tobacco. The Centers for Disease Control and Prevention found that 62% of 12–17-year-old smokers usually bought their own cigarettes and almost half (45%) had *never* been asked to show proof of age.¹⁰² Strong, strictly enforced, youth access laws can, however, reduce illegal sales to minors. These laws can also help reduce tobacco use among minors.

- A comprehensive youth access program in Illinois reduced sales to minors from 70% to less than 5% during 1½ years, with a corresponding 50% decrease in regular tobacco use among youths.¹⁰³

- Interventions involving local ordinances and enforcing limits on youth access to tobacco had a significant affect on smoking rates, perceived availability of cigarettes, and reported use of commercial sources for cigarettes.¹⁰⁴

Use of School-Based Intervention Programs

Education and health are closely linked. The schools are an important opportunity to impact behavior and impact social determinants of health. Since the mid-1970s, more than 90 controlled trials of school-based tobacco use prevention interventions have been published. School-based programs reduce the initiation of tobacco use by adolescents^{105,106} and decrease the proportion of adolescents using tobacco.^{107,108,109} The most successful of these programs involve teaching the skills to resist social pressures to use tobacco, along with the short- and long-term consequences of using tobacco.¹¹⁰

Restricted Tobacco Marketing and Promotion

While the tobacco settlement will prohibit direct marketing and promotion targeting adolescents by tobacco companies and their contractors, it is important to recognize the influence these activities have had historically. Prior to the settlement, tobacco companies spent more than \$13 million every day (\$5 billion each year) on marketing and advertising.¹¹¹ Industry documents, such as that excerpted below, make clear the importance placed on the youth market:

Today's teenager is tomorrow's potential regular customer, and the overwhelming majority of smokers first begin to smoke while still in their teens.... The smoking patterns of teenagers are particularly important to Philip Morris. (1981 Philip Morris internal document)

Studies documenting the success of industry marketing show that when advertising for the new Joe CamelTM campaign jumped from \$27 million to \$43 million, Camel's market share among youth increased by more than 50%, while its adult market share did not change at all.¹¹² Marketing efforts to counteract these effects are underway and preliminary reports reveal an important change in the social acceptability of tobacco use.

Advancing Biomedical, Epidemiological, and Behavioral Research

Through research and development, the links between the causes of disease and their health impact are increasingly understood. Continued investment into research of tobacco-related illnesses will enhance our understanding and provide new opportunities for continued efforts to improve health. Expanded investments in understanding the initiation of tobacco use, subsequent tobacco addiction, and successful cessation programs will result in important tools for daily use by clinicians.

Controlling Environmental Tobacco Smoke

Policies that limit exposure to second-hand smoke in public can positively influence health. For example, California recently banned smoking in all

restaurants and bars. In adult non-smoking bartenders who were exposed to second hand smoke, clinical symptoms and lung function dramatically improved after eliminating exposure to active smoking from their place of work.¹¹³ Reduction of second-hand smoke in homes has been shown to reduce asthma exacerbation and health care utilization by children with smoking parents.

Summary of Interventions

These eight major activities—1) increasing public education, 2) improving professional education, 3) increasing use of tobacco cessation programs by clinicians, 4) limiting youth access to tobacco, 5) use of school-based intervention programs, 6) restricting tobacco marketing and promotion, 7) advancing epidemiological and behavioral research, and 8) controlling environmental tobacco smoke—require the collective support of individuals, clinicians, public health supporters, communities, and policy makers. Through multi-pronged efforts, dramatic decreases in tobacco use, better prevention of illness and disease, and improvement in health can be attained.

Conclusion

The tobacco settlement will provide Arkansas with more than \$1.6 billion dollars through the year 2025, or approximately \$53 million per year. National resources will also be established as part of the settlement that may benefit Arkansans. These include national public education efforts, activities to decrease youth smoking, and legal tools to enforce limits on tobacco company activities.

States are not directed how to use payments from the tobacco companies, under the current agreement. Therefore, a critical opportunity now exists to advance every Arkansan's health through intentional and specific investment in disease prevention and health promoting activities.

If Arkansas is to achieve its full potential for better health, the settlement proceeds must be used wisely. Each day, families, communities, and the state are robbed of their most valuable resource—their people. To avoid this loss and to achieve a more healthy and productive citizenry, Arkansas must take advantage of the opportunity represented by the tobacco settlement. The state must ensure that individuals are encouraged, the health care system is motivated, and our government is accountable for decreasing the personal and economic impact of tobacco use.

We must establish focused and successful disease prevention and health promotion strategies. The principles proposed by the Arkansas Center for Health Improvement are intended to provide assistance to Arkansas Legislators and the Governor in optimizing the future health and productivity of our citizens, ensuring Arkansas' growth into the next century.

Appendix

Arkansas' Share of Tobacco Settlement^{1,114}

Approximate yearly payments:

1998	\$19.9 million
2000	\$53.1 million
2001	\$57.3 million
2002	\$68.8 million
2003	\$69.5 million
2004–2007	\$58.0 million
2008–2017	\$59.1 million
2018–2025	\$66.3 million

Total payments to Arkansas through 2025 = \$1,622,338,125

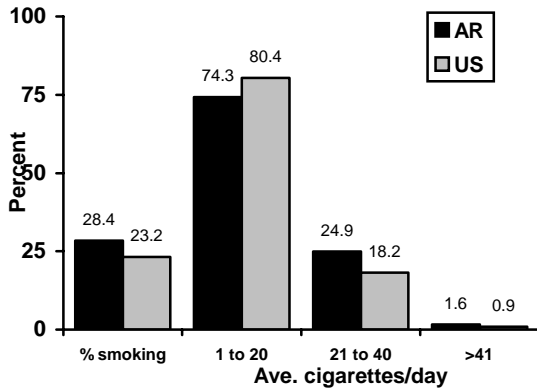
Highlights of the Tobacco Settlement*

- The tobacco industry will fund a \$25-million national foundation to study programs for teen-smoking and substance-abuse reduction and tobacco-related disease prevention.
- A national public education fund of \$1.45 billion will be established to promote tobacco control and to implement educational programs to counter youth smoking.
- Targeting of youth in advertising, promotions, or marketing of tobacco products is prohibited.
- Advertising of tobacco products outdoors or on transit facilities is banned and limits are placed on advertisements outside retail establishments.
- Distribution and sale of apparel and merchandise with brand-name logos is prohibited.
- Product placement and sponsorships of public events are prohibited or limited.
- Distribution of free samples is forbidden, except in closed facilities where no underage (<18 years) persons are present.
- Gifts without proof of age are not allowed.
- Tobacco companies are not allowed to lobby against proposals intended to limit youth access to or consumption of tobacco products.
- Research about the health outcomes related to tobacco use cannot be suppressed or misrepresented by the industry.

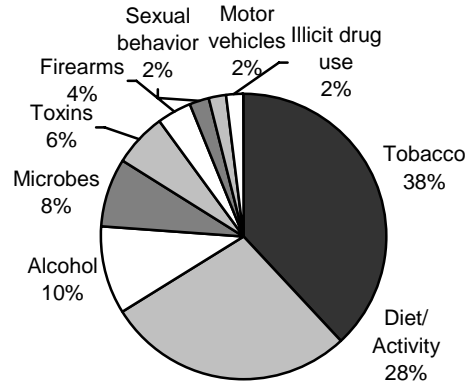
**To date, no mechanisms have been established to ensure that these aspects are enforced or that these national resources benefit Arkansans.*

Quick Graphics

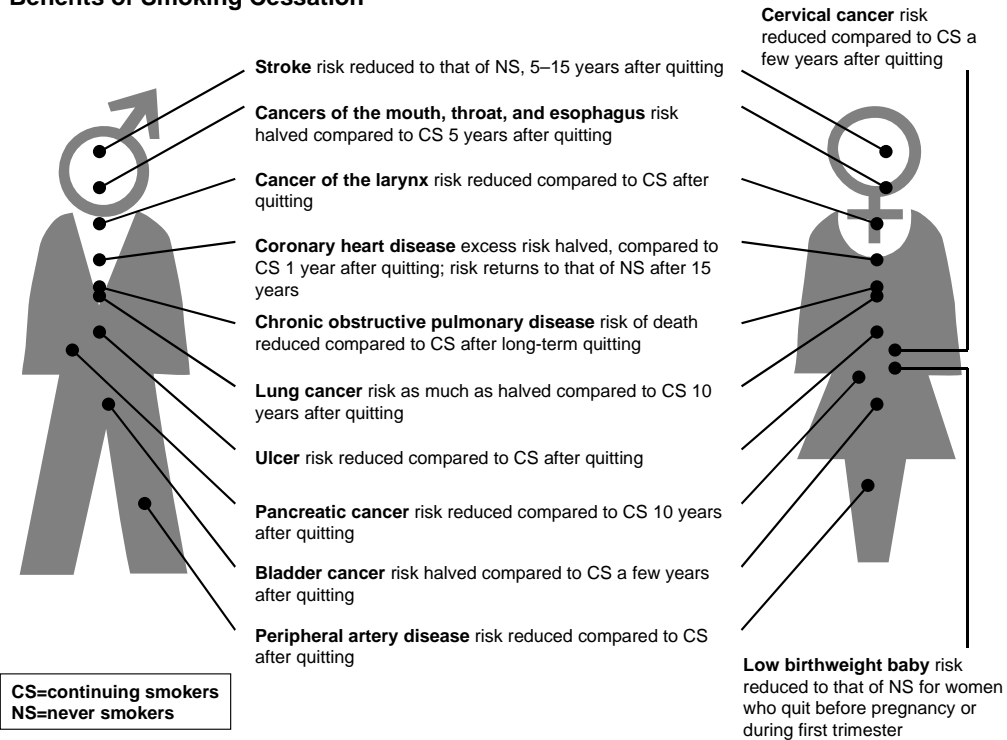
Tobacco Use Prevalence¹¹⁵



Preventable Causes of Death in the US (50% of total deaths)



Benefits of Smoking Cessation



Adapted from Centers for Disease Control, Office on Smoking and Health. *The Health Benefits of Smoking Cessation: A Report of the Surgeon General, At a Glance, 1990*. Rockville, MD: Centers for disease Control: 1990. USDHHS Publication CDC 90-8419.

Arkansas Tobacco Facts

- Arkansas has the 3rd highest smoking rate in the nation with more than 1 in 4 adults in the state smoking.
- This year, 2,300 Arkansans will be diagnosed with lung cancer and 2,200 will die of lung cancer; almost all of these deaths will be related to smoking cigarettes.^{8,20}
- Lung cancer in Arkansas kills more men than prostate cancer and more women than breast cancer
- Tobacco use is associated with 87% of lung cancers.
- Each day, 300 Arkansans under the age of 18 become regular smokers.
- Almost 3 out of 4 adolescents (73%) have tried cigarettes by the time they reach 9th grade; this experimentation has become a habit for nearly half of 12th graders with 49% smoking at least once a month.
- Of reproductive age women, 27% smoke; this habit will have a direct affect on the health of their newborns including low birth weight and poor pregnancy outcomes.
- Approximately 178,000 of the state's children and adolescents are exposed to second-hand smoke in their homes.¹⁸
- Smokeless tobacco use is reported among 14% of Arkansas youths in grades 9–12.
- Current smokers are twice as likely lack health insurance compared to non-smokers.¹¹⁶
- Smokers who quit reduce their chances of heart attack by 50% within 1 year of quitting.

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