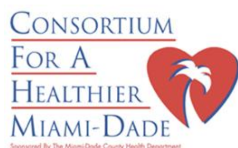
Tobacco Kills: A Major Issue for Floridians



A Miami-Dade County Health Department White Paper

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Table of Contents

Cover Page and Acknowlegement 1-2

Table of Contents 3

Preface 4

Introduction 5

Problem Statement 9

Steps for Improvement 12

Summary 14

Appendix 15

Glossary 19

References 20

Preface

As noted by researchers and scientists alike, “Tobacco remains the leading cause of preventable death and disease in the United States” (USDHHS, 1994& 2006b). Smoking continues to be linked to serious health effects such as heart disease, cancer and respiratory problems. In Florida, 29,000 deaths per year are due to tobacco use and this number continues to rise (USDHHS, 1994 & 2006b).

Since 1989, the State of Florida and the Department of Health and Rehabilitative Services has been actively involved in tobacco prevention and education (FDOH, 2007; Givel, MS & Glantz, SA, 1999 May 1). Secondly, the State of Florida settled with the tobacco industry for $11.3 Billion dollars in 1997 (FDOH, 2007; Givel, MS & Glantz, SA, 1999 May 1). As a result of the settlement, Florida was able to implement a Tobacco Pilot Program which specifically targeted tobacco use amongst youth (FDOH, 2007; Givel, MS & Glantz, SA, 1999 May 1; Riordan, M, 2008 March 24). However, with gains comes a loss. The program received cuts each year since its inception but received the greatest cuts in 2002 (FDOH, 2007; Riordan, M, 2008 March 24). In 2002, five years after the settlement, Florida legislatures and the governor cut the tobacco funding to $1 million (FDOH, 2007; Riordan, M, 2008 March 24). This cut has affected their tobacco initiatives specifically programs targeting the youth population (FDOH, 2007; Riordan, M, 2008 March 24).

The State of Florida, since the passing of the 2007 Florida Legislature, has made strides to re-implement and expand existing programs by reinvigorating a statewide comprehensive tobacco prevention and control program (FDOH, 2007; The Florida Senate, 2006). In November 2006, Floridians saw the need to increase tobacco programs by identifying tobacco as a serious public health problem (FDOH, 2007; The Florida Senate, 2006). Floridians voted to implement a constitutional amendment focusing on tobacco use. The constitutional amendment stated that Legislature will use a portion of the tobacco settlement money annually for a comprehensive statewide tobacco education and prevention program with the Center for Disease Control and Prevention Best Practices being used as a guideline (FDOH, 2007; The Florida Senate, 2006). As indicated, the funding would consist of 15% of the 2005 Tobacco Settlement Payments to Florida with an adjustment performed each year due to inflation on an annual basis (FDOH, 2007; The Florida Senate, 2006).

The goal of the Florida Tobacco Prevention and Control Program is to provide free cessation services, a statewide tobacco prevention media campaign, youth and chronic disease programs and evaluation services in collaboration with community partners (FDOH, 2007). As noted by Dr. Ana Viamonte Ros, the Florida State Surgeon General, “Florida once again aspires to lead the nation in reducing the number of youth who smoke, increasing the number of adults who quit, and minimizing secondhand exposure among all Floridians” (FDOH, 2007). This white paper will address the underlining issues relating to the aforementioned initiatives in Florida by focusing on the following topics: health and financial benefits of eliminating tobacco use and exposure to secondhand smoke, increasing the

cigarette user fee, engaging advocates on implementing tobacco-free policies, and banning the sale of flavored tobacco products to youth (FDOH, 2007).

Introduction

Tobacco Use

The World Health Organization (WHO) (2008) has indicated that 5 million deaths per year worldwide are due to tobacco use. It is estimated that the number of deaths is expected to increase to 8 million by 2030 (CDC, 2008, May 23). Nationally, big tobacco kills nearly half a million Americans each year (USDHHS, 2006, July). Additionally, one in every six deaths is due to tobacco use (ALA, 2007 May).

As noted in the Surgeon General's Report and in current research findings, smoking is the leading cause of premature death (USDHHS, 2006b). Smoking has been known to cause cardiovascular disease, lung cancer, pneumonia, stroke and respiratory problems in smokers and nonsmokers alike (ALA, 2007, May; USDHHS, 2006, July). Tobacco smoke is said to contain over 4,800 chemicals, with approximately 69 of these chemicals suspected to cause cancer (ALA, 2007, May). Some of these chemicals include formaldehyde, benzene, vinyl chloride, arsenic ammonia and hydrogen cyanide. Additionally, smoking is responsible for 90% of lung cancer deaths and over 80% of Chronic Obstructive Pulmonary Disorder (COPD) deaths (emphysema and chronic bronchitis) (ALA, 2007, May). There are approximately 9 million Americans with smoking related illnesses (USDHHS, 2006b & July 2006). Each day tobacco kills approximately 88 Floridians (CTFK, 2008).

The need to reduce tobacco use throughout Florida, specifically in Miami-Dade County is imperative. The 2006 Community Health Survey noted the following about Miami-Dade County: 21.3% of residents were former smokers, 4.3% occasional smokers, 7.5% were regular smokers, and 66.9% never smoked (PRC, Inc, 2006) [Figure 1]. Secondly, 11.8% of adults who currently smoke cigarettes is on par with the Healthy People 2010 target (12% or lower) [Figure 2] (PRC, Inc, 2006). Though the prevalence of smoking in Miami-Dade County is more favorable than the prevalence nationwide (22%) and State-wide (21.7%), however, is less favorable in South Miami-Dade County (12.4%) (PRC, Inc, 2006). According to the 2006 Community Health Survey, approximately 217,900 current smokers reside in Miami-Dade County. Prevalence of Cigarette smoking has been found to be higher amongst White and/or Hispanic respondents and women (8.4%) of child bearing age (ages 18-44) in Miami-Dade County (PRC, Inc, 2006). These demographic characteristics are of concern since tobacco use increases the risk of infertility, miscarriage, stillbirth, SIDS and low birth weight for women who smoke during pregnancy (PRC, Inc, 2006).

Financial Benefits

Tobacco has always been one of the oldest and most profitable industries in the United States. British Broadcasting Corporation (BBC) News (1999, September

28) indicated that $45 billion dollars is spent annually on tobacco sales in the US. The tobacco industry is also nicknamed the “Golden Leaf” due to the dual benefits for both the tobacco companies and US government. BBC News (1999, September 28) noted that, “The US government makes seven times more money from the sale of a pack of cigarettes than a cigarette maker does” [Figure 3]. It is estimated that the tobacco industry provides 50,000 manufacturing jobs and 400,000 jobs indirectly, in the US (WHO, 1999 & 2008). In addition, the federal budget consists of funding provided through the profits of the tobacco industry (BBC News, 1999, September 28). Worldwide 33 million people are currently employed through tobacco farming and over 120,000 tobacco farms are housed in the United States (WHO, 1999 & 2008).

The tobacco industry over the years has been hit by increases in the price of the cigarette, higher state taxes and litigation costs (Boon, A., 2008 August 1). Due to the increase in these prices the tobacco industry has begun to shift their attention to younger markets and developed products that are more appealing to them, such as candy flavored tobacco products (CFTFK, 2008). It is estimated that the tobacco industry spends $930.4 million throughout Florida on advertising and promoting tobacco products, which is more than the tobacco industry spends in any other state (Boon, A., 2008 August 1; U.S. FTC, 2007a & 2007b). Nationally, the tobacco industry spends $13.36 billion on advertisement and promotion (U.S. FTC, 2007.). These numbers are alarming since a majority of these marketing tactics are spent on targeting youth (U.S. FTC, 2007 & 2007b).

Tobacco Products and Youth

The tobacco industry continues to be influential in targeting our youth and encouraging them to initiate using tobacco through their marketing tactics. The rates of tobacco initiation amongst the youth have steadily begun to rise as the marketing strategies and production of flavored tobacco products continues to increase (CTFK, 2008). CDC (December 2006) estimated that 23% of high school students in the United States are current smokers. Additionally, 8% of middle school students in the United States are current smokers. From 2003-2005, cigarette use amongst high school students has remained unchanged (CDC, 2006, July 27) [Table 1]. The highest rates of tobacco use in the high school and middle school populations are found in the Caucasian and Hispanic population. It is estimated that 4,000 youth each year attempt their first cigarette and 1,140 of them become addicted and become long term tobacco users (CDC, 2006, July 27). There are many reasons why youth initiate use of tobacco, some of the motives are: low socioeconomic status, peer pressure, social status (looks cool, accepted behavior by peers), have a family member who smokes, accessibility, availability and price of tobacco products, a perception that tobacco use is normative, lack of parental support or involvement, low levels of academic achievement, lack of skills to resist influences to tobacco use, lower self-image or self-esteem, belief in functional benefits of tobacco use, and lack of self-efficacy to refuse offers of tobacco (CDC, 2006, July 27). In addition, tobacco use is typically associated with high risk behaviors amongst youth, such as high risk sexual behavior, use of alcohol and other recreational drugs (CDC, 2006, Dec).

The tobacco industry has been influential in grabbing the youth's attention through their marketing tactics (CFTFK, 2008). The advertisements used to market tobacco products employ a tactic that misleads smokers on the adverse health effects of smoking (CFTFK, 2008). Research has shown that cigarettes are harder to quit and easier to get addicted to, due to the addition of flavored additives, menthol and greater amounts of nicotine. The Massachusetts Department of Health noted in a recent study that the level of nicotine consumed in a cigarette has increased by 10% over the last 6 years (MDOH, 2006). In addition, the top three products used by the youth are Marlboro, Newport and Camel (CFTFK, 2008; MDOH, 2006) [Figure 4]. It is through this white paper we hope to encourage our community to work towards banning the sale of flavored tobacco products to the youth population.

Secondhand Smoke

Secondhand Smoke (SHS) is also known as environmental tobacco smoke (ETS) and passive smoke (ALA, 2007a, June; Glantz & Parmley, 2001 & Werner, RM & Pearson, TA, 1998, January 14). SHS is a combination of two forms of smoke expelled by the burning of tobacco products (ALA, 2007a, June; Glantz & Parmley, 2001 & Werner, RM & Pearson, TA, 1998, January 14). SHS consists of side-stream smoke and main-stream smoke (ALA, 2007a, June; Glantz & Parmley, 2001 & Werner, RM & Pearson, TA, 1998, January 14). Side-stream smoke is the smoke that is released between the puffs of a burning cigarette, pipe or cigar (ALA, 2007a, June; Glantz & Parmley, 2001 & Werner, RM & Pearson, TA, 1998, January 14). Main-stream smoke is the smoke that is exhaled by the smoker while having a cigarette (ALA, 2007a, June; Glantz & Parmley, 2001 & Werner, RM & Pearson, TA, 1998, January 14). SHS is the third leading cause of preventable death in the United States (ALA, 2007a, June; Glantz & Parmley, 2001 & Werner, RM & Pearson, TA, 1998, January 14).

Secondhand smoke (SHS) is a combination of the smoke exhaled by the smoker plus the smoke created by the burning of a lit cigarette (ALA, 2007a, June; Glantz & Parmley, 2001 & Werner, RM & Pearson, TA, 1998, January 14). SHS is toxic, containing over 4000 chemical compounds, 200 of which are poisonous and over 60 are known to be carcinogenic (US EPA, 1992 December). The Environmental Protection Agency (EPA) classified SHS as a Group A carcinogen, indicative of the true danger passive smoke poses to a nonsmokers health (1992 December). No level of exposure to SHS is recommended (CDC, 2001, Dec. 14 & 2005, July 8; USHHS, 2006b). At any level of exposure, the risk for cancer related problems, respiratory problems and cardiovascular diseases exist (USHHS, 2006b). SHS exposure causes disease and premature death in both children and adults who are non-smokers (ALA, 2007a). SHS causes 3,400 lung cancer deaths and 22,700-69,600 of heart disease related deaths in nonsmokers each year. (CDC, 2001, Dec. 14 & 2005, July 8). Throughout Florida, tobacco use accounts for 28,700 deaths each year (CDC, 2001, Dec. 14 & 2005, July 8). It is estimated that 2,390 – 4,250 deaths are due to exposure to SHS (CDC, 2001, Dec. 14 & 2005, July 8). Nonsmokers are exposed to SHS in many locations, such as: workplace, bars, restaurants, public places, car and home (CDC, 2001, Dec. 14 & 2005, July 8).

Nonsmokers exposed to SHS in all locations especially at the workplace are at a greater risk for adverse health effects (CDC, 2001, Dec. 14 & 2005, July 8). More than 126 million nonsmoking Americans continue to be exposed to secondhand smoke in homes, vehicles, public places, and workplaces (CDC, 2001, Dec. 14 & 2005, July 8). In fact, rates of SHS are 2 to 6 times higher in the office setting as compared to homes with smokers, thus placing nonsmoking employees at a greater risk for adverse health effects (CDC, 2001, Dec. 14 & 2005, July 8).

Research findings continue to show the importance of preventing the exposure of SHS. SHS leads to a greater risk of death and cardiovascular disease compared to smoking (Glantz, SA & Parmley, WW, 2001). Glantz & Parmley (2001) noted the following concerning the associated risk of exposure to SHS, "Secondhand Smoke increases the risk by 30% of cardiac death and morbidity compared to active smoking. The direct effect of secondhand smoke is as high as one third of the effect of active smoking." SHS has similar affects on children as it does on adults (USEPA, 1992 December). Studies have shown that SHS causes sudden infant death syndrome, low birth weight, chronic middle ear infections, and respiratory illnesses such as asthma, bronchitis, and pneumonia in children (CDC, 2001, Dec. 14). SHS has been proven to impact the cognitive ability of children due to the neurotoxicity of environmental tobacco smoke (ALA, 2006, August & 2007b, June; Becklake, MR, Ghezzo, H. & Ernst, P, 2005 August 16; USHHS, 2006b). Research suggests that 21.9 million children are at risk of reading, math and visual-spatial reasoning deficits due to exposure to SHS (ALA, 2006, August & 2007b, June; USHHS, 2006b). Maternal smoking is also linked to the development of antisocial behavior and attention-deficit hyperactive disorder symptoms in children (Becklake, M.R., Ghezzo, H. & Ernst, P., 2005 August 16). Additionally, exposure to SHS increases the risk of youth having metabolic syndrome, which is linked to the development of heart disease, stroke, and diabetes as the child progresses into adulthood (ALA, 2006, August & 2007b, June; USHHS, 2006b). The SHS rate of exposure for a child is directly correlated with the chance of the child becoming a smoker (Becklake, M.R., Ghezzo, H. & Ernst, P., 2005 August 16). These findings are important as children follow the example of the adults in their lives and are impact by their health behaviors (ALA, 2006, August & 2007b, June; USHHS, 2006b). One of the underline goals of this white paper is to educate the public about the adverse health effects of SHS and encourage the workplaces to become tobacco-free.

Smoking Policies and Smoking Restriction Policies

Due to the State Surgeon Generals reports in 1986 and 2006, which stated that SHS is the third leading cause of preventable death, the state enacted a law to protect the health of residents from exposure to SHS (USDHHS, 2000a & 2006b). In 1985, the Florida Clean Indoor Act (FCIAA) was implemented to protect people from the hazards of secondhand tobacco smoke (FDOH, 2007, September; Florida Legislature, n.d.). In 2003, The (FCIAA) was expanded to include all indoor workplaces, as indicated the purpose was "to protect people from the health hazards of secondhand tobacco smoke and to implement the Florida health initiative in section 20, Article X of the State Constitution. However, the intent of this legislation

is not to inhibit, or otherwise obstruct, medical or scientific research or smoking cessation programs approved by the Department of Health" (USEPA, 2008; FDOH, 2007, September; Florida Legislature, n.d.). The FCIAA defines an enclosed indoor workplace as "any place where one or more persons engages in work, and which place is predominantly or totally bounded on all sides and above by physical barriers, regardless of whether such barriers consists of or include, without limitation, uncovered openings; or open or closed window, jalousies, doors, or the like" (USEPA, 2008; FDOH, 2007, September; Florida Legislature, n.d.). Some examples of an indoor workplace are: tenant buildings, shopping malls, child/adult care centers, convenient stores, salons, public libraries, auditoriums/theaters, and educational facilities (FDOH, 2007). The FCIAA also instituted penalties relating to the violation of this policy, "Any person who violates s. 386.204, F.S., commits a noncriminal violation as defined in s. 775.08 (3), F.S., punishable by a fine of not more than $100 for the first violation and not more than $500 for each subsequent violation. Jurisdiction shall be with the appropriate county court (s.386.208, F.S.)" (FDOH, 2007; Florida Legislature, n.d). Many establishments follow the law provided within the FCIAA concerning clean air (USEPA, 2008; FDOH, 2007, September; Florida Legislature, n.d.). The goal of this white paper is to encourage businesses and establishments to become tobacco-free.

Problem Statement

Secondhand Smoke

This white paper discusses the importance of protecting the public from the health hazards of secondhand smoke and implementing the Florida Health Initiative in section 20, Article X of the State Constitution. SHS is known to affect all Americans, both youth and adults (Kuehnm, B., 2006; USDHHS, 2006b). Studies have shown that children exposed to SHS are at greater risk of respiratory problems, sudden infant death syndrome and middle ear infections; and adults acquire immediate and long term effects on overall health and increase their risk of cardiovascular disease and lung cancer (Kuehnm, B., 2006; USDHHS, 2006b). This supports the notion that there is no safe level of exposure to secondhand smoke (Kuehnm, B., 2006; USDHHS, 2006b).

In children and adults, who have pre-existing respiratory problems or asthma, exposure to SHS can trigger bronchopulmonary responses that can cause serious life-threatening problems (Kuehnm, B., 2006; USDHHS, 2006b). In addition, an infant's exposure to nicotine or the chemicals found in tobacco smoke can affect the neuroregulation of breathing and the development of sleep apnea (Kuehnm, B., 2006; USDHHS, 2006b). Exposure to the carcinogens in SHS can lead to DNA damage that causes the development of cancer (Kuehnm, B., 2006; USDHHS, 2006b). Surgeon General Carmona (June 27, 2006) noted that those exposed to SHS and those who smoke experience similar negative health effects (Kuehnm, B., 2006; USDHHS, 2006b). This is evident by the dose-response relationship between the development of lung cancer and exposure to SHS, which is similar to the dose-response relationship between smoking and lung cancer (Kuehnm, B., 2006; USDHHS, 2006b). The risk associated with SHS has been proven to be a major

issue in our society, as more Americans are exposed to SHS (Kuehnm, B., 2006; USDHHS, 2006b). It is important that as a nation we address the issue of exposure to SHS both in personal environment and in public establishments.

Financial Costs

Though the tobacco industry provides benefits for the US government, it also provides costs (WHO, 1999 & 2008). In the US, $92 Billion dollars is lost in economic opportunities due to tobacco-related deaths (WHO, 1999 & 2008). The economic burden due to tobacco related deaths has been show to have the greatest impact on developing countries (WHO, 1999 & 2008). By 2030, four out of five deaths will be due to tobacco use (WHO, 1999 & 2008). Tobacco-related health-care costs are approximately $81 billion yearly in the US (WHO, 1999 & 2008). The economic impact is most evident amongst the poor (WHO, 1999 & 2008). It is evident that money spent on tobacco products is money that is not spent on basic necessities such as food and shelter (WHO, 1999 & 2008). In addition, the poor is at greater risk of dying prematurely due to tobacco related diseases therefore, perpetuating the cycle of illness (WHO, 1999 & 2008).

In the State of Florida, it is estimated that 6.32 billion is spent annually on health care cost related to tobacco use (RWJF, 2008, November 18). Additionally, $60.2 million is spent on tobacco prevention throughout the state in comparison to $930.4 million which is spent by the tobacco industry on marketing (RWJF, 2008, November 18). A pack of cigarettes, in the state of Florida, cost $3-$4 dollars; however, health costs and productivity losses are double the cost of a pack of cigarettes (RWJF, 2008, November 18). Cigarette smoking continues to be costly to both smokers and non-smokers alike (RWJF, 2008, November 18).

Smoke Free and Smoking Restriction Policies

As noted above, exposure to SHS is a critical issue; and reinforcing the restriction of smoking in public establishments and workplaces is important. Since 2001, many states have implemented either smoking restrictions or smoke-free policies prohibiting smoking in all workplaces (Glantz, SA & Parmley, WW, 2001; Florida Legislature, n.d.). The Healthy People 2010 Objective 27-13 calls for agencies to focus on establishing laws on smoke-free indoor air that prohibit smoking or limit it to separately ventilated areas in public places and worksites (USDHHS, 2000 November & 2006a). Since the implementation of this objective, the Centers for Disease Control and Prevention (CDC) recently completed a study assessing the status of the establishment of these regulations in 2007 (ANRF, 2008). This report indicated a substantial increase in changes concerning smoke-free establishments and providing protection for nonsmokers from SHS (ANRF, 2008). The report separates the state regulations concerning smoke free establishments into four categories which are the following: no restrictions, designated smoking areas required or allowed, no smoking allowed or designated smoking areas allowed if separately ventilated, and no smoking allowed (ANRF, 2008). Based upon the data compiled from the CDC's State Tobacco Activities Tracking and Evaluation System database, Florida from December 31st, 2004 to

December 31st, 2007, has implemented smoke-free regulations in both private-sector worksites and restaurants (ANRF, 2008). However, there are no smoking restrictions in bars [Figures 5-7]. Though there have been strides to implement smoking restrictions in public establishments, it is important to implement smoking restrictions in bars and establishments with no existing smoking restrictions (ANRF, 2008). In order to combat the issue of SHS, it is important to have 100% smoke free establishments (USDHHS, 2006a).

Secondly, many Americans are unaware of their exposure to SHS. Based upon data collected by the State Tobacco Activities Tracking and Evaluation System, in 1996, only 37% of adult nonsmokers were aware of their exposure to SHS either at home or at work (CDC, 2008). Additionally, from 1992–93, a National Cancer Institute (NCI) survey found that significant numbers of workers reported smoke-free workplace policy rates considerably lower than the overall rate of 46 percent (CDC, 2008). Many restaurants, clubs and bars do not have smoke free regulations in turn impacting the health of their staff (CDC, 2008). In a 1993 study, food service workers were estimated to have a 50 percent increased risk of dying from lung cancer compared to the general population, with the higher risk attributed in part to their workplace exposure to SHS (CDC, 2008). The underlining problem that exists is that multiple paths are needed to reduce exposure to SHS. Individuals, who are unaware of their risk of exposure to SHS, are not able to reduce their risk.

Tobacco Products and Youth

One of the primary problems with the production of flavored products is that they are used to initiate new users amongst the youth (CFTFK, 2008). Additional problems are the fact that the Food and Drug Administration does not regulate tobacco products. The Big Tobacco's Guinea Pigs: How an Unregulated Industry Experiments on America's Kids and Consumers report indicated the lack of regulation on tobacco products, "the ongoing product manipulation by the tobacco companies with no government oversight and without regard to health impact demonstrates just how critical it is that the FDA be given authority to regulate tobacco and its marketing, just as it has for virtually all other consumer products (CFTFK, 2008). It is important that we work towards banning the production of flavored tobacco products, especially those marketed to the youth." (CFTFK, 2008). The tobacco industry has been influential in countering declining smoking rates and growing restrictions on smoking through the production of new products (CFTFK, 2008). The tobacco industry has developed a range of products from flavored products, smokeless products, safer cigarettes and cigarettes with higher nicotine levels (CFTFK, 2008). The industry has created an array of cigarettes, smokeless tobacco products, and little cigars in a variety of candy, fruit, and alcohol flavors to facilitate the consumption of tobacco in children (CFTFK, 2008). Research has shown that the primary goal of the tobacco industry is to recruit, create, sustain and discourage smokers from quitting (CFTFK, 2008). Since the inception of the tobacco industry tobacco products have been manufactured to addict youth, "they (tobacco products) are highly engineered nicotine delivery devices, finely tuned to appeal to the taste, feel, smell, and other sensations of new and addicted smokers" (CFTFK, 2008). The tobacco industry is aware that the first attempt at smoking is

unpleasant (CFTFK, 2008). Therefore, they have redesigned tobacco products by adjusting the mouth feel of the cigarette and how quickly the products lights up (CFTFK, 2008). This is most evident with Camel's tobacco products, "Camel's share among 18 year olds increased dramatically from 2.5 percent in 1985 to 14 percent in 1993" (CFTFK, 2008). In 1993, Camel became known as a young adult smoker cigarette. RJ Reynolds (RJT) has been the most aggressive in this country in the production of flavored products they have created a dozen flavors within the Camel Exotic Blends such as 'Twista Lime' (CFTFK, 2008). Expansive ads marketing these products have been placed in magazines such as Rolling Stone and Sports Illustrated (CFTFK, 2008). The production of flavored tobacco products continues to rise, at least once every quarter a new flavored tobacco product is released (CFTFK, 2008).

In addition, to traditional cigarettes, spit tobacco and little cigars are now produced with various appealing flavors, for example, Swisher, Inc offers chocolate, strawberry, peach, and grape flavored products (CFTFK, 2008). Many of these products are mistaken for candies due to the packing and location of the products in the stores (CFTFK, 2008). Some of the cigars are sold separately rather than in a pack and look like a cigarette, misleading the consumer (CFTFK, 2008). In addition, they are sold at a lower price due to the lower excise tax placed on the product making them more affordable for youth (CFTFK, 2008). The tobacco industry has always been instrumental in manipulating their products to grab the public's attention (CFTFK, 2008). They continue to make tobacco products more addictive, more appealing and more deadly as each year progress (CFTFK, 2008). It is important that health care professionals make strides to combat this epidemic and stop the tobacco industry from advertising to the youth (CFTFK, 2008).

Steps for Improvement

In addressing some of items described in the problem statement it is necessary to focus on three areas: Tobacco Use & Youth, Financial Benefits of Tobacco Use and Implementing Smoke-free policies.

Tobacco Use and Youth

In 2007, two bipartisan bills, which granted the Food and Drugs Administration (FDA) authority to regulate tobacco products, were presented by US Senators Edward Kennedy and John Cornyn (CFTFK, 2008). This legislation would allow for regulation of the marketing of tobacco products as well (CFTFK, 2008). In addition, these legislations would assist in the reduction of new tobacco users and increase the number of individuals who quit smoking (CFTFK, 2008). These legislations addressed some of the major issues pending with the tobacco industry, such as:

- Restrict the marketing of tobacco products to child and limit tobacco advertising in point-of-sale locations.
- Require tobacco companies to provide detailed information about the product and additives included.

- Ban the production of candy and fruit flavorings in cigarettes.
- Limit misleading terminology on tobacco products such as the use of light or mild cigarettes.
- Prohibit the use of explicit or implicit health claims on products by the tobacco industry.
- Require larger and more informative health warnings on products.

The bipartisan legislation has been endorsed by agencies such as the American Cancer Society, Cancer Action Network, American Heart Association, American Lung Association and the Campaign for Tobacco-Free Kids. Due to the lack of regulation by the FDA on tobacco products the public's health continues to be unprotected (CFTFK, 2008). It is important to encourage the passing of the bipartisan legislation to protect the health of the public and reduce initiation of smoking in youths (CFTFK, 2008). On July 30, 2008, the US House cast a historic vote to protect youth from tobacco by granting the FDA the ability to regulate tobacco products (CFTFK, 2008). The House voted a clear veto-proof margin of 326 to 102 which shows the bipartisan support for this legislation and promise for this becoming a bill within the next year (CFTFK, 2008).

Benefits of Tobacco User Fees

Financial and health benefits are visible in the reduction of smokers (Boonn, A., 2008, August 1; Lindblom, E., 2007, February 15). Research has been shown that by increasing the tobacco user fee the number of smokers will reduced. Since 1990, Florida has not increased the tobacco user fee (Boonn, A., 2008, August 1; Lindblom, E., 2007, February 15). The State of Florida ranks 46th in relation to the tobacco user fee with a taxation of only 33.9 cents per pack of cigarettes (Boonn, A., 2008, August 1; Lindblom, E., 2007, February 15). The national average tobacco user fee is $1.18 per pack of cigarettes (Boonn, A., 2008, August 1; Lindblom, E., 2007, February 15). It is estimated that over 125,000 Floridians will quit smoking due to the increase of the price of a pack of cigarettes (Boonn, A., 2008, August 1; Lindblom, E., 2007, February 15). Additionally, research has shown that for every 10% increase in the price of a pack of cigarettes, smoking decreases by 4% and the number of youth who smoke will decrease by 7% statewide (Boonn, A., 2008, August 1; Lindblom, E., 2007, February 15). By increasing the tobacco user fee by $1, the number of new and long term smokers decreases (Boonn, A., 2008, August 1; Lindblom, E., 2007, February 15). It is estimated that on average a smoker spends approximately $2,100 on cigarettes annually (Boonn, A., 2008, August 1; Lindblom, E., 2007, February 15). The state of Florida is currently undergoing a budget crisis with a reduction of $4.5 billion in funding the 2008-2009 Fiscal Year (Boonn, A., 2008, August 1; Lindblom, E., 2007, February 15). The rising of the tobacco user fee to $1 would provide revenue of $1.1 billion dollars for the state of Florida to assist in compensating for some of the lost in funding for 2008-2009 Fiscal Year (Boonn, A., 2008, August 1; Lindblom, E., 2007, February 15). It is crucial to encourage the passing of an increase of the tobacco user fee in order to reduce the number of smokers in Florida.

Smoke free policies and FICAA

Floridians are being protected from SHS, though there is still more work to be done (CDC, 2005, July 8 & 2006, October 27; MMWR, 2008). The Florida Clean Indoor Act (FCIAA) was enacted in 1985 and was elaborated in 2003 to include indoor workplaces. In addition, the call to action within the Healthy People 2010 Objective 27-13 request that the establishment of laws relating to smoking regulations are initiated in all 50 states (USDHHS, 2000 November.). This call to action has assisted in the progress of the implementation of smoking restrictions in all 50 states. It is estimated that as of 2008, 33% of Americans are living under state or local laws that make worksites, restaurants, and bars completely smoke-free, and 64% have smoking restrictions such as designated smoking areas or ventilated smoking areas (MMWR, 2008). Though strides have been put in place to enforce the FCIAA, the following steps have been established by the World Bank Health to encourage the establishment of smoke-free campuses and workplaces (The World Bank, 2003 October; USDHHS, 2000b)

- Assess current regulations concerning smoking at establishment.
- Establish a written policy with cooperation from the staff
- Implement smoking policy within a reasonable time frame
- Monitor and enforce smoking policy
- Place signage indicating where smoking is allowed and is not allowed.
- Provide documentation, to all staff, about smoking regulation with indication of repercussions of not following the policy.
- Develop penalties for lack of compliance with policy.
- Develop format for documenting infraction.
- Document cases of infraction.
- Provide smoking cessation services, for those employees wishing to quit

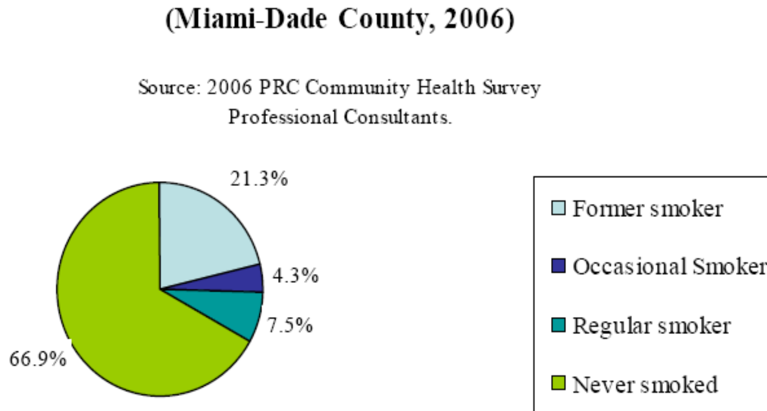
It is with the enactment and enforcement of such policies that can truly make the public establishments safe for employees and visitors alike (The World Bank, 2003 October; USDHHS, 2000b). It is important to reduce exposure to SHS by committing to be smoke free and enforce the FICAA.

Summary

In short, this white paper provides an overview of the history of tobacco use, prevention and control within the state of Florida. Florida has made great strides in protecting the health of their residents and continues to do so by the implementation of a statewide tobacco prevention program. This white paper has provided the basis for the community and employers to understand the need to address exposure to secondhand smoke, to implement smoke-free policies and protect youths from the tactics used by the tobacco industry.

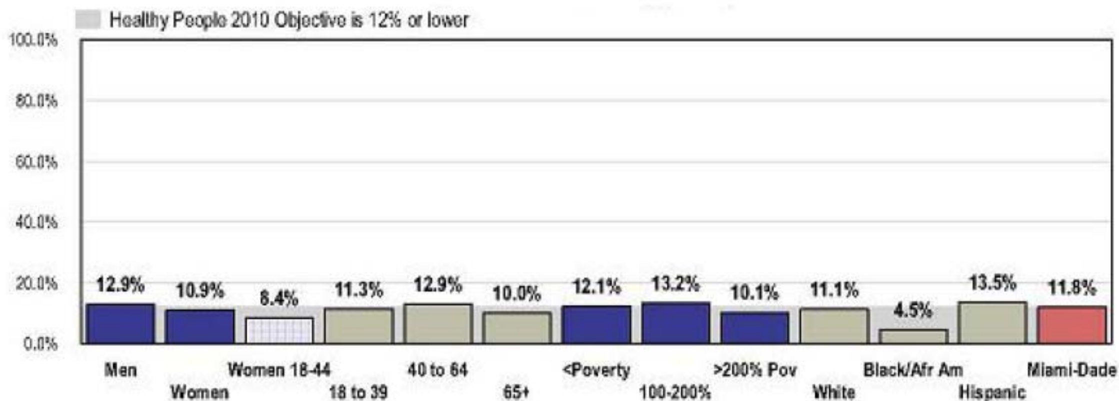
Appendix

Figure 1. Cigarette Smoking Prevalence in Miami Dade County, 2006.



Source: Professional Research Consultants, Inc. (2006) 2006 PRC community health survey living healthy, living longer in Miami Dade County, Florida. Retrieved June 6, 2008 from: http://www.dadehealth.org/downloads/LHLL%20Final%20Report%200607.pdf

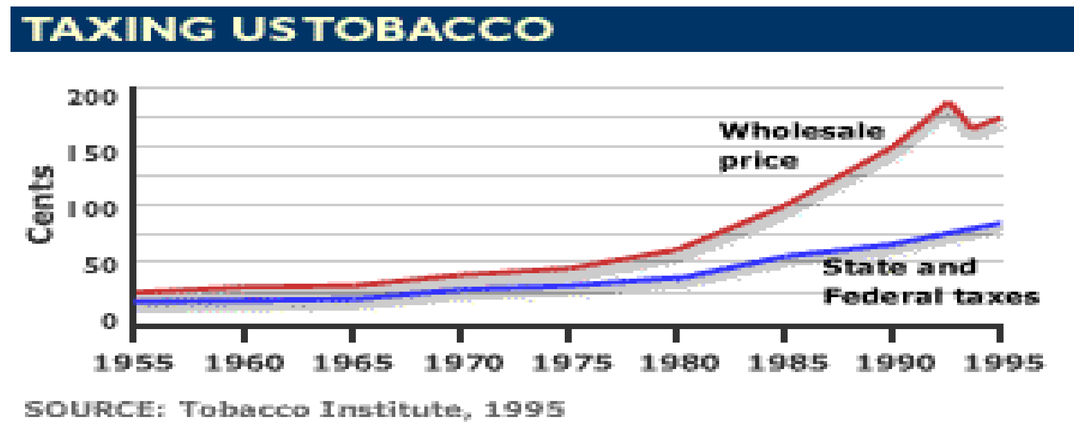
Figure 2. Data on Current Smokers within Miami-Dade broken down by demographics.



Sources:

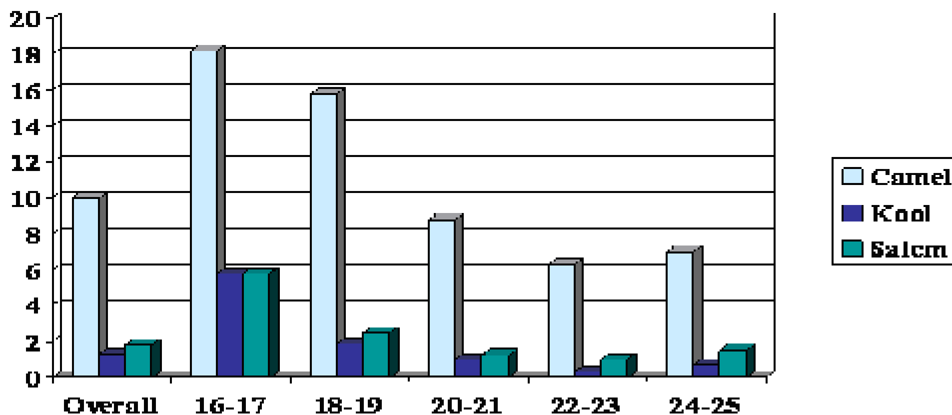
- Professional Research Consultants, Inc. (2006) 2006 PRC community health survey living healthy, living longer in Miami Dade county, Florida. Retrieved June 6, 2008 from: http://www.dadehealth.org/downloads/LHLL%20Final%20Report%200607.pdf
- United States Department of Health and Human Services (2000, November). Healthy People 2010, 2nd Edition [Objective 27-1a]. Washington, DC: US Government Printing Office.

Figure 3: Taxing US Tobacco



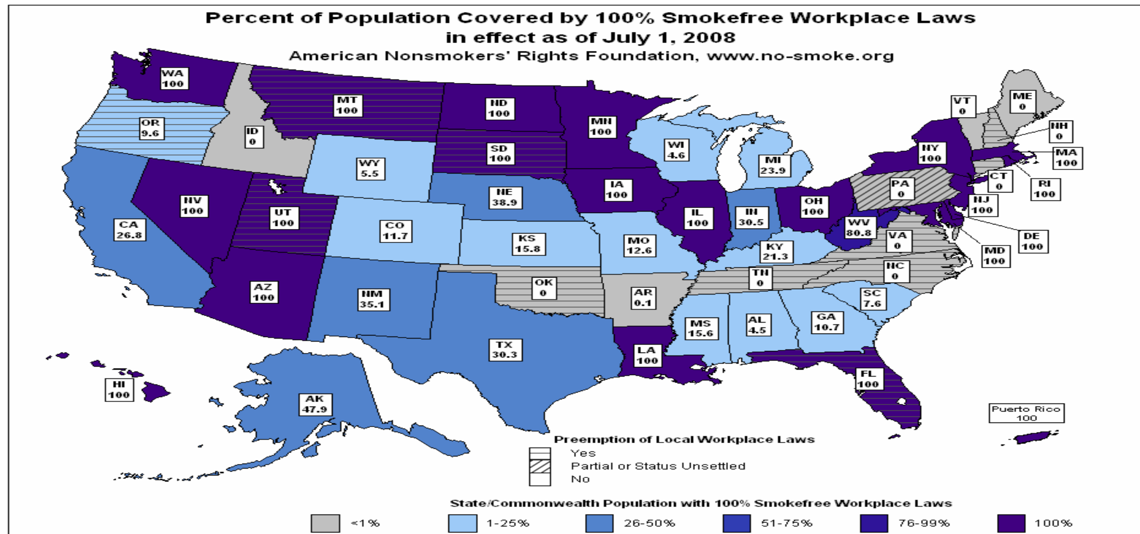
Source: BBC News (1999, September 28). Business: The company file the economics of tobacco. *British Broadcasting Corporation News*. Retrieved June 30, 2008, from: http://news.bbc.co.uk/1/hi/business/the_company_file/459157.stm

Figure 4. Young Smokers Use of Camel, Kool, or Salem Flavored Cigarettes During the Previous 30 Days, by Age – United States, 2004.



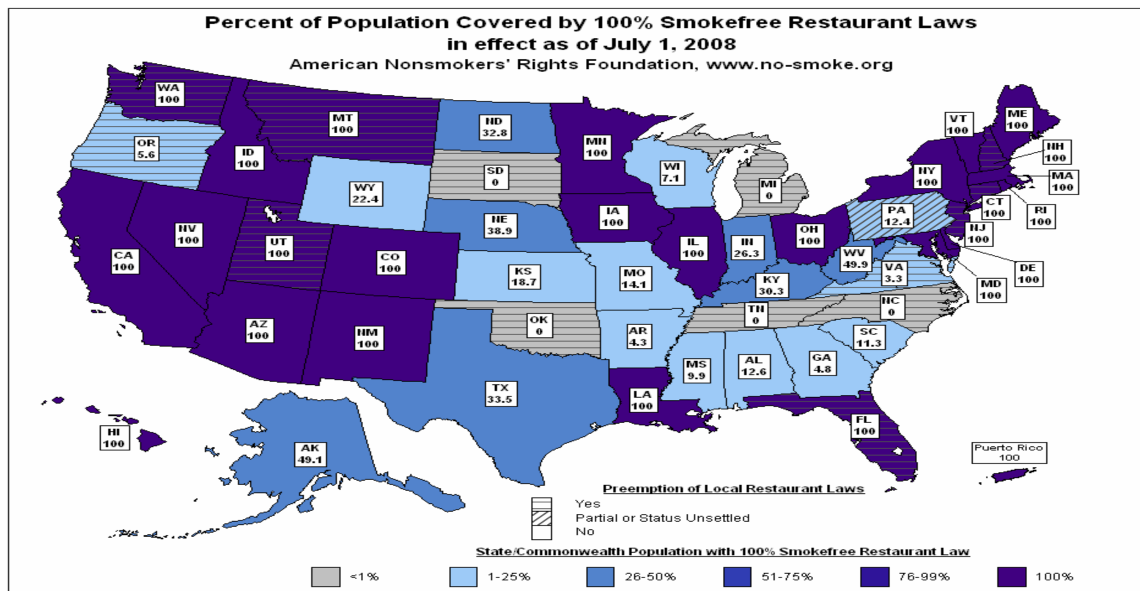
Source: Campaign for Tobacco Free Kids (2008). Big tobacco's guinea pigs: How an unregulated industry experiments on America's kids and consumers. Retrieved June 4, 2008 from: http://www.tobaccofreekids.org/reports/products/

Figure 5. Percent of Population Covered by 100% Smokefree Workplace Laws in effect as of July 1, 2008.



Source: Americans for Nonsmokers Rights Foundation (2008) Smokefree Lists, Maps and Data. Retrieved June 15, 2008, from: http://www.no-smoke.org/goingsmokefree.php?id=519

Figure 6. Percent of Population Covered by 100% Smokefree Restaurant Laws in effect as of July 1, 2008.



Source: Americans for Nonsmokers Rights Foundation (2008) Smokefree Lists, Maps and Data. Retrieved June 15, 2008, from: http://www.no-smoke.org/goingsmokefree.php?id=519

Figure 7. Percent of Population Covered by 100% Smokefree Bar Laws in effect as of July 1, 2008.

Source: Americans for Nonsmokers Rights Foundation (2008) Smokefree Lists, Maps and Data. Retrieved June 15, 2008, from: http://www.no-smoke.org/goingsmokefree.php?id=519

Table 1. Percentage of high school students who reported lifetime cigarette use, current cigarette use, and current frequent cigarette use – Youth Risk Behavior Survey, United States, 1991-2005.

TABLE 1. Percentage of high school students who reported lifetime cigarette use,* current cigarette use,† and current frequent cigarette use§ — Youth Risk Behavior Survey, United States, 1991–2005¶

Category	1991 % (95% CI**)	1993 % (95% CI)	1995 % (95% CI)	1997 % (95% CI)	1999 % (95% CI)	2001 % (95% CI)	2003 % (95% CI)	2005 % (95% CI)
Lifetime	70.1 (±2.2)	69.5 (±1.4)	71.3 (±1.7)	70.2 (±1.9)	70.4 (±2.9)	63.9 (±2.1)	58.4 (±3.1)	54.3 (±3.0)††§§
Current	27.5 (±2.7)	30.5 (±1.9)	34.8 (±2.2)	36.4 (±2.3)	34.8 (±2.5)	28.5 (±2.0)	21.9 (±2.1)	23.0 (±2.3)††§§
Current frequent	12.7 (±2.2)	13.8 (±1.7)	16.1 (±2.6)	16.7 (±1.9)	16.8 (±2.6)	13.8 (±1.6)	9.7 (±1.4)	9.4 (±1.5)††§§

* Ever smoked cigarettes, even one or two puffs.
† Smoked cigarettes on ≥1 of the 30 days preceding the survey.
§ Smoked cigarettes on ≥20 of the 30 days preceding the survey.
¶ Linear and quadratic trend analyses were conducted using a logistic regression model controlling for sex, race/ethnicity, and grade. Prevalence estimates shown here were not standardized by demographic variables.
** Confidence interval.
†† Significant linear effect ($p<0.05$).
§§ Significant quadratic effect ($p<0.05$).

Source: Centers for Disease Control and Prevention (2006, July 7). Cigarette Use Among High School Students – United States, 1991-2005. Morbidity and Mortality Weekly Report [serial online]. 2006: 55(26); 724-726 [cited 2006 Dec 5]. Retrieved June 4, 2008, from: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5526a2.htm.

Glossary

Center for Disease Control and Prevention (CDC): a federal agency in the Department of Health and Human Services; located in Atlanta; investigates and diagnoses and tries to control or prevent diseases (especially new and unusual diseases)

Department of Health and Rehabilitative Services: a federal agency whose mission is to promote and protect the health and safety of all residents in this state through the establishment and maintenance of high quality standards for the public health environment and the delivery of public health services.

Environmental Tobacco Smoke: see Secondhand Smoke

Flavored Tobacco Products: The addition of flavorings or additives such as grape, vanilla, green apple to a tobacco product to enhance the flavor or aroma.

Florida Clean Indoor Air Act (FCIAA): FCIAA was enacted by the Florida Legislature in 1985. The goal of FCIAA is to protect people from the hazards of second-hand smoke and to implement the Florida health initiative in s.20, Art. X of the state constitution.

Main-stream smoke: Main-stream smoke is the smoke that is exhaled by the smoker while having a cigarette.

Passive Smoke: see Secondhand Smoke

Secondhand Smoke (SHS): Environmental tobacco smoke that is inhaled involuntarily or passively by someone who is not smoking. Environmental tobacco smoke is generated from the side stream (the burning end) of a cigarette, pipe or cigar or from the exhaled mainstream (the smoke puffed out by smokers) of cigarettes, pipes, and cigars.

Side-stream smoke: Side-stream smoke is the smoke that is released between the puffs of a burning cigarette, pipe or cigar.

Smoke-free: an establishment that has little or no smoke present such as a smoke-free office or workplace.

World Health Organization (WHO): An agency of the United Nations established in 1948 to further international cooperation in improving health condition. The World Health Organization promotes the highest possible level of health by all people. WHO's primary headquarters is located in Geneva.

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