Tobacco as a Social Justice Issue

Remarks of Dr. Cheryl Healton

President and CEO,

American Legacy Foundation®,

before a plenary session of the

National Conference on Tobacco or Health

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Dr. Cheryl Healton, President and CEO of the American Legacy Foundation

On November 27, 2001, Dr. Cheryl Healton, president and CEO of the American Legacy Foundation, addressed the National Conference on Tobacco or Health on the subject, "Tobacco as a Social Justice Issue." Dr. Healton described the excess burden that tobacco places on society's poor and underserved populations and recommended ways to expand access to cessation services. She called upon the federal government to hold the tobacco industry accountable for decades of deceptive business practices. And she urged the states to fulfill their moral obligation to use Master Settlement Agreement funds to protect their citizens from future harm from tobacco. The full text of Dr. Healton's remarks follows.

address to the National Conference on Tobacco or Health

Thank you. Being here today makes me feel like I've come full circle. My mother died of smoking at age 62. I started smoking as a girl. As a young woman, I waited tables at the Howard Johnson's in Times Square in New York where I was constantly exposed to not only my own smoke but to secondhand smoke, as waitresses continue to be in too many places. I finally quit for good in 1992, and at this Thanksgiving season, like all Thanksgiving seasons, I am happy to just "be" because I well know the implications of my years of heavy smoking. I am also thankful for the chance to work with the American Legacy Foundation and to be with all of you today.

As a woman and former smoker, I have a personal understanding of tobacco as a social justice issue, which is the subject of my remarks. And as a public health professional, I have a broader understanding of health as a social justice issue. But before I address these issues, I want to briefly discuss a few recent developments in our field.

First, I'm sure we were all excited to learn that the folks at Philip Morris are changing – at least their name – to "Altria," which is Latin for "high." While they may think they're "high," some of us may wonder what they've been smoking.

The second recent development that I want to mention is 9/11. Cigarette consumption has been on the rise since the attacks. The American Cancer Society released a study on November 14 that reported that approximately 30 percent of smokers have increased their smoking since 9/11, and that more than five percent of former smokers have picked up their cigarettes again.[1] A Legacy study found similar results in New York City. Nearly 30 percent of smokers in New York City reported smoking more since 9/11; within this population the average increase was one-half a pack.[2] This may explain why the tobacco industry, which was enjoying record profits even before 9/11[3], has been one of the best-performing industries in the stock market in the

1 Smokers encouraged to join the American Cancer Society's 25th annual Great American Smokeout. (2001). *PRNewswire.* Retrieved January 30, 2001, from http://www.prnewswire.com.

2 Research Triangle Institute. (2001). [Analysis of American Legacy Foundation Media Tracking Survey IV]. Unpublished raw data.

3 Fonda, D. (2001). Why tobacco won't quit. *Time Magazine, 157(26),* 38-39.

weeks since the attacks. Compare that with the tens of thousands of low-income workers thrown out of their jobs in the travel, hospitality, restaurant, and other service industries as a result of the attacks. Big Tobacco gets bigger while the little guy gets littler.

Among the goals of pursuing justice are to hold those who have done wrong accountable, and, if necessary, to force wrongdoers to change their bad behavior. It would be difficult to find a corporate wrongdoer more deserving of justice than the tobacco industry.

Many of you are familiar with the federal government's lawsuit against the tobacco industry, filed in September 1999 – *United States* v. *Philip Morris, Inc*.

The suit seeks to hold the tobacco industry accountable for nearly 50 years of what the government alleges are illegal and harmful practices, such as deceiving the public about the health risks of smoking and the addictive nature of nicotine, and marketing to children.

The lawsuit seeks:

- The return of profits obtained through illegal acts;
- Disclosure of all relevant internal cigarette company research on smoking and health;
- Payments to establish programs to address the ongoing effects of the companies' illegal conduct (such as funds for cessation, research, public education and counter-advertising); and
- Permanent injunctions against:
  1) Making false, misleading, or deceptive statements about cigarettes;
  2) Engaging in public relations campaigns that misrepresent or suppress information about the harm from smoking or its addictiveness, including the low-tar farce; and
  3) Marketing to kids.

On September 28, 2000, Judge Gladys Kessler canceled two of the government's claims (those brought under the

Medical Care Recovery Act and the Medicare Secondary Payer Act), but ruled that the case could go forward, and that the government's claims under the Racketeer and Corrupt Organizations (RICO) Act were valid. Judge Kessler stated, "while the government's theories of liability have been limited, the extent of Defendants' potential liability remains, in the estimation of both parties, in the billions of dollars."[4]

No one should be surprised that "killing" the federal lawsuit remains one of the top priorities of the tobacco industry and that the current Administration appears ready to do their bidding. This spring, while Attorney General John Ashcroft announced he would seek to settle the case, anonymous Administration officials told the press they believed the case was "weak."[5] In addition, the Attorney General has, for months, refused to provide adequate funding for his own department's litigation effort. The Administration's actions have been heavily criticized by public health and tobacco control organizations. Fortunately, settlement talks with the tobacco industry are said to have foundered and the Administration now appears to be moving forward with the case, set for trial in June 2003.

Just two weeks ago, on November 15, 2001, the Department of Justice filed hundreds of pages of expert reports documenting the tobacco industry's pattern of fraudulent behavior dating back to the 1954 "frank statement."

In a nutshell, the federal lawsuit is about whether or not the most powerful government in the world can force what is arguably the most powerful industry in the world to change the practices that have brought so much harm to so many. If the case is allowed to go to trial, we may find out the answer! And if it's the right one, we might be on the road to social justice.

We usually think of ourselves as being in the better health business, and we don't usually see ourselves as being crusaders for social justice. But we are, because smoking is not – as Hollywood would like us to believe – a lifestyle choice of the rich and famous. In the real world, smoking is an affliction of the young, the poor, the depressed, the stressed out, the uninsured, the less

4 Stout, D. (2000). Judge dismisses part of U.S. tobacco suit. *The New York Times.* p. A22.

5 Campaign for Tobacco Free Kids. (2001). *Introducing Philip Morris's latest cost-saving device.* Retrieved January 31, 2001, from http://tobaccofreekids.org/reports.

educated, the blue-collar worker, the minority group member, the ill-at-ease college freshman, and the young gay man making the urban bar scene seeking social entree with a cigarette in hand.

The tobacco industry has succeeded in addicting those who have the least information about the health risks of smoking, the fewest resources, the fewest social supports, and the least access to cessation services. The link between smoking and low income and lower levels of education cannot be overemphasized. Tobacco is not an equal-opportunity killer.

Americans below the poverty line are over 40 percent more likely to smoke than those at or above the poverty line.[6] A study done by the World Bank concluded that tobacco may be responsible for more than half the difference in adult male mortality between those of highest and lowest socioeconomic status.[7] The poor are not only more likely to smoke, they are less likely to quit.[8]

Education is another key indicator. Nearly 38 percent of all Americans with only 9 to 11 years of education smoke, compared to just 13 percent of those with an undergraduate college degree.[9] Girls and women with only 9 to 11 years of education are nearly 15 times more likely to smoke during pregnancy than women with four years of college.[10]

Secondhand smoke is also a major social justice issue. Over half of all white-collar workers are covered by smoke-free policies in their work places, compared to only about a third of

6 U.S. Centers for Disease Control and Prevention. (2001). Cigarette smoking among adults – United States, 1999. *Morbidity and Mortality Weekly Report, 50(40)*, 869-873.

7 The World Bank. (1999). Health consequences of smoking. *Curbing the epidemic: Governments and the economics of tobacco control.* Retrieved January 30, 2001, from http://www1.worldbank.org/tobacco/book/html/chapter2.htm.

8 Flint, A.J., & Novotny, E.T. (1997). Poverty status and cigarette smoking prevalence and cessation in the United States, 1983-1993: The independent risk of being poor. *Tobacco Control, 6(1)*, 14-18.

9 U.S. Centers for Disease Control and Prevention. (2001). Cigarette smoking among adults – United States, 1999. *Morbidity and Mortality Weekly Report, 50(40)*, 869-873.

10 Matthews, T.J. (2001). Smoking during pregnancy in the 1990s. *National Vital Statistics Report, 49(7)*. Hyattsville, MD: National Center for Health Statistics.

all service workers and only a little more than a quarter of blue-collar workers.[11] One study found that food service workers exposed to secondhand smoke have a 50 percent excess risk of lung cancer.[12] Being a waitress isn't a crime, and it shouldn't carry the death penalty.

The link between smoking and heart disease and cancers has serious health implications for the poor, women, and minorities. Multiple researchers have found that women, minorities, and those of lower income are diagnosed later for heart disease and cancer than well-off white men and receive fewer interventions.[13-17] The pattern is clear: more likely to start to smoke; more likely to continue; less likely to receive timely intervention; more likely to die younger.

Flint and Novotny[18] examined poverty and smoking prevalence and cessation, and reported that "poverty may be an indicator of underparticipation in the

11 Gerlach, K.K., Shopland, D.R., Hartman, A.M., Gibson, J.T., & Pechacek, T.F. (1997). Workplace smoking policies in the United States: Results of a national survey of more than 100,000 workers. *Tobacco Control, 6(3),* 199-206.

12 Siegel, M. (1993). Involuntary smoking in the restaurant workplace: A review of employee exposure and health effects. *Journal of the American Medical Association, 270(4),* 490-493.

13 Fiscella, K., Franks, P., Gold, M.R., & Clancy, C.M. (2000). Inequality in quality: Addressing socio-economic, racial and ethnic disparities in health care. *Journal of the American Medical Association, 283(19),* 2579-2584.

14 Schnieder, E.C., Zaslavsky, A.M., & Epstein, A.M. (2002). Racial disparities in the quality of care for enrollees in Medicare managed care. *Journal of the American Medical Association, 287(10),* 1288-1294.

15 Bradley, C.J., Given, C.W., & Roberts, C. (2001). Disparities in cancer diagnosis and survival. *Cancer, 91(1),* 178-188.

16 Hiatt, R.A., Pasick, R.J., Stewart, S., Bloom, J., Davis, P., Gardiner, P., Johnston, M., Luce, J., Schorr, K., Brunner, W., & Stroud F. (2001). Community-based cancer screening for underserved women: Design and baseline findings from the Breast and Cervical Cancer Intervention Study. *Preventive Medicine, 33(3),* 190-203.

17 Shavers, V.L., & Brown, M.L. (2002). Racial and ethnic disparities in the receipt of cancer treatment. *Journal of the National Cancer Institute, 94(5),* 334-357.

18 Flint, A.J., & Novotny, E.T. (1997). Poverty status and cigarette smoking prevalence and cessation in the United States, 1983-1993: The independent risk of being poor. *Tobacco Control, 6(1),* 14-18.

changing social norms regarding smoking behavior in recent years," and "further research may be needed to understand why poverty is a persistent independent marker" of smoking.

We know that some smokers who are poor turn to tobacco because they feel it is a source of pleasure in a cruel world. I can also tell you that in some poor communities, buying your own cigarettes is a status symbol – it shows that you have disposable income. Bringing social justice to these communities will take a lot more than tobacco control. It will require our entire society to deal more effectively with broader issues such as racism in all its manifestations. It is safe to say that tobacco is just barely on the radar screen of leaders in poor communities, despite the fact that it is the single greatest preventable cause of death. It must compete with other pressing problems.

In the meantime, many low-income men and women addicted to nicotine must choose between buying cigarettes or purchasing family necessities. Their children, in turn, are more likely to grow up to be smokers because they see their parents smoke.[19] A smoking parent is a walking billboard for the tobacco industry.

And if the children of the poor turn out to be sensation-seeking teenagers, they will be more likely to become lifelong smokers than their sensation-seeking peers who come from more affluent backgrounds and have greater educational opportunities. Teens who smoke in high school but who go to good schools and grow up to be lawyers are far less likely to smoke in adulthood than teens who are trapped in failing schools, who are told they're not good enough to go to college, and who end up flipping burgers.

The quest for social justice must begin with the states. Blessed with billions of Master Settlement Agreement dollars, the states have an historic opportunity to launch proven programs to prevent and reduce smoking.

But the states are letting this crucial opportunity slip away. So far, they've received about $20 billion in MSA payments, but have devoted only five percent to tobacco control.[20] This is happening in spite of the fact that the

19 U.S. Department of Health and Human Services. (2001). *Women and Smoking: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General. p. 468.

20 Dixon, L. (2001). *State Management and Allocation of Tobacco Settlement Revenue, 1999 to 2001*. Washington, DC: National Conference of State Legislatures. p.16.

money in the agreement – approximately $206 billion – is supposed to compensate the states for the costs they incurred providing treatment to members of the Medicaid population suffering smoking-related illnesses.

In simple terms, Settlement dollars are the blood money of the poor, and yet the states – with some notable exceptions – have made little effort to provide even the minimal amount of dollars recommended by the CDC to advance tobacco control.

We must say to the states: Why did you move against the tobacco industry? Was it to protect your citizens from smoking, the No. 1 cause of death and disease? Or was it just a game of pork-barrel politics?

We should not, of course, be too surprised by all of this. When it comes to tobacco, public health policy in our country is for sale, and it has been bought by the tobacco industry. This is not generally the case with other major public health problems, and we should resist its continuing to be the case with tobacco.

On the federal level, the four largest cigarette manufacturers spend over $106,000 lobbying Congress for each day that Congress meets.[21] Half of our federal elected officials have accepted tobacco donations.[22]

We must also say to the states that raising taxes on tobacco products is right because it reduces consumption. But higher taxes take a much bigger bite out of the budget of the poor smoker than the well-off smoker. Higher taxes on cigarettes should not be a form of social injustice. States that raise taxes have a moral obligation to use these funds to expand prevention and cessation programs.

As important as government is, public and private health care systems must also play a much larger role. We have effective treatments that can dramatically increase the likelihood of long-term cessation.[23] These include the

21 Action on Smoking and Health. (2001). *Tobacco spends over $100,000 daily for lobbying in DC.* Retrieved February 10, 2002, from http://no-smoking.org/oct01/10-23-01-1.html.

22 Campaign for Tobacco-Free Kids. (2002). *Buying influence, selling death: Campaign contributions by tobacco interests.* Retrieved February 10, 2002, from http://tobaccofreekids.org/reports/contributions/.

23 Fiore, M.C. (2000). *Treating tobacco use and dependence: Quick reference guide for clinicians.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service.

intensive treatments that low-income smokers often require. But our health care system is simply not set up to deliver these interventions in a regular and efficient way. A number of steps must be taken.

Health care providers need more training in how to deliver these interventions. Every clinic should have a tobacco-user identification system, plus dedicated staff to provide treatments. Every HMO and other private insurers should include tobacco dependence treatments as paid or covered services. And they should reimburse clinicians and specialists for delivery of treatments and include interventions among the defined duties of clinicians.

In addition, every state must offer comprehensive Medicaid coverage to make smoking cessation affordable for the poor. Currently, 17 states offer no coverage at all, and only one state – Oregon – provides coverage for all the appropriate pharmacotherapies and counseling services.[24] And most important, America must get on with the task of insuring the tens of millions of people who have no health insurance at all, a group that probably includes a large proportion of smokers. Secondhand smoke can be markedly reduced by passing clean air laws and resisting preemption efforts by the industry. These laws lower population-based smoking rates by making smoking less socially acceptable and increasing quit attempts.[25]

For our part, the American Legacy Foundation is working to meet our commitments to assist vulnerable populations. Our multi-cultural **truth**[sm] campaign is the largest counter-marketing campaign ever conducted to prevent youth smoking. This year, Legacy is investing over $100 million in the campaign and its evaluation – more than any national social marketing effort in the history of public health. The tobacco industry is annoyed that we are telling the "**truth**[sm]" to youth, and I've gotten some pretty harsh letters and other feedback from tobacco companies complaining about it.

A few days from now you will also hear some exciting news about Legacy's plans to help pregnant women quit

24 Schauffler, H.H., Barker, D.C., & Orleans, C.T. (2001). Medicaid coverage for tobacco-dependence treatments. *Health Affairs, 20(1),* 298-303.

25 Bitton, A., Fichtenberg, C., & Glantz, S. (2001). Reducing smoking prevalence to 10% in five years. *Journal of the American Medical Association, 286(21),* 2733-2734.

smoking. Each year, nearly one-half million women smoke during pregnancy. If efforts to assist women to quit during this time succeeded, we could substantially reduce the 25 million women who smoke early on – before most of the damage is done to them and their young children. We could also take a big bite out of health care costs.

This is part of our overarching Women and Smoking Initiative, which will be the centerpiece of our activities aimed at helping women smokers during the coming year. On your chair is a certificate to receive a Sunburst pin designed by world renowned Angela Cummings. This pin – which signifies hope for a smoke-free society – is our symbol to raise awareness about the toll tobacco takes on women and families.

And on November 5, Legacy announced $8.5 million in grants to 32 organizations in 18 states to help reduce tobacco use among priority populations. Another round of funding next year will bring our total commitment to $21 million.

These grants fund innovative programs to serve low-socioeconomic groups, African Americans, Hispanics, Native Americans, gays and lesbians, Asian Americans, and Alaska Natives. Let me give you a few examples:

- One project will establish female support groups for African-American women trying to quit in major cities, including right here in New Orleans;
- In the tobacco-growing eastern Tennessee region, a county anti-tobacco coalition will partner with community groups to serve low-income communities;
- The Lesbian and Gay Community Services Center in New York will offer tobacco prevention, intervention, and advocacy services to lesbian, gay, bisexual, and transgender youth. These young people are at substantially greater risk of smoking – many are "throwaway" youth having been rejected by their families because of their sexual orientation; and
- The Albuquerque, New Mexico, Area Indian Health Board will create community-based tribal tobacco councils to develop tobacco reduction initiatives consistent with community values.

Social Justice

In all of our efforts, Legacy stands on the shoulders of some giants who came before us. These include the leaders of state public health programs like Dileep Bal and Greg Connolly; private sector leaders like Steven Schroeder, Nancy Kaufman, Karen Gerlach, Tracy Orleans, and Matt Myers; and association leaders like John Seffrin, John Garrison, and Cass Wheeler. And there is one new giant – filling the big shoes of Michael Erikson – Rosemarie Henson, who will join us for the closing when she returns from Geneva. Rosemarie is a public health trooper who has fought in the women's health trenches for years addressing AIDS, breast cancer, cervical cancer, and environmental justice. She will bring a fresh perspective to the work of the CDC in a complex time when great political skill is needed to keep tobacco control on the national agenda.

We live in a nation that values human life. We demanded the recall of Bridgestone/Firestone tires when they were connected to 271 deaths.[26] I wonder if it wouldn't be a good idea to demand the recall of tobacco products that kill about 271 Americans every 5 1/2 hours[27]... that leave 12,000 children motherless each year in the U.S. alone[28]... and that take an average 14 years of life from each smoking woman who dies of tobacco-related causes.[29]

That might bring us the social justice we seek, at long last. Thank you all very much.

— Cheryl Healton, Dr.P.H.

26 National Highway Traffic Safety Administration. (2001). *Firestone tire recall.* Retrieved November 15, 2001, from http://www.nhtsa.dot.gov/hot/Firestone/Index.html.

27 Calculation based on a figure of 430,000 smoking-related deaths per year from Smoking-attributable Mortality, Morbidity and Economic Costs (SAMMEC) version 3.0, cited in: Centers for Disease Control and Prevention. (1999). *Investment in tobacco control: State highlights – 1999.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

28 Leistikow, B.N., Martin, D.C., & Milano, C.E. (2000). Estimates of smoking-attributable deaths at ages 15-54, motherless or fatherless youths, and resulting Social Security costs in the United States in 1994. *Preventive Medicine, 30(5),* 353-360.

29 U.S. Department of Health and Human Services. (2001). *Women and smoking: A report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General. p.193.

Dr. Healton

Dr. Cheryl Healton is a researcher, professor, and public health administrator with more than 20 years experience. She has been at the forefront of some of the most important efforts to improve public health in America. She has been one of the leading voices in the development of policies and programs to prevent and treat HIV/AIDS, substance abuse, and violence, and to promote women's health.

Before joining Legacy, Dr. Healton served as head of the Division of Sociomedical Sciences and as Associate Dean for Program Development at the Columbia University School of Public Health. She founded and directed the school's Center for Applied Public Health, conceptualizing and implementing applied research in emerging issues in public health, including AIDS care for women and children, staffing and burnout at AIDS care organizations, training and development for AIDS care professionals, and the computer networking of medical records.

Dr. Healton has extensive experience in tobacco control issues. She developed a program to study the effects of tobacco marketing and counter-marketing on youth tobacco use for the Centers for Disease Control and Prevention. She also developed a series of prevention partnerships linking public health researchers with New York State tobacco health policymakers, and she has evaluated intervention programs for the state's largest youth tobacco prevention program.

Working at Columbia to bring an interdisciplinary approach to tobacco control and prevention, Dr. Healton developed innovative grants linking academic researchers to public health practitioners in the field. She wrote a chapter on cessation and smoking policy in the recently published *Treatment of the Hard Core Smoker,* edited by Yino Covey and Dan Seidman.

Dr. Healton continues to serve as a professor of Clinical Public Health at Columbia, where she is instrumental in developing course offerings for public health professionals on topics such as tobacco policy, tobacco interventions, and tobacco control through distance learning and the Internet.

Dr. Healton has won three public health awards. The New York Public Health Association cited her award-winning radio campaign to improve public health. The U.S. Department of Health and Human Services recognized her leadership in developing the National Pediatric AIDS prevention marketing campaign. And the New York Department of Health cited her "years of outstanding contributions to public health" in 2000.

Dr. Healton holds a doctorate from the Columbia University School of Public Health and a master's degree in Public Administration (Health Policy and Planning) from New York University.

The American Legacy Foundation is a national, independent, public health foundation located in Washington, DC, dedicated to fighting for the health and well-being of all generations of Americans.

Legacy collaborates with organizations interested in decreasing tobacco consumption to achieve the goals of reducing youth tobacco use, decreasing exposure to secondhand smoke, increasing successful quit rates, and improving access to tobacco prevention and cessation services for all populations.

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