Comprehensive Tobacco Control Funding

for the

State of Georgia

A Proposal by the
Georgia Tobacco Task Force

9/02/2008

The following document outlines a recommendation plan for the Georgia Division of Public Health to allocate Master Settlement Agreement appropriations for the upcoming fiscal year to augment Tobacco Control programming throughout the state. Task Force members and their representative organizations are noted for identification purposes; however, the conclusions of the report do not necessarily represent the official positions of the organizations.

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EXECUTIVE SUMMARY

If current patterns of smoking are not reduced in Georgia, CDC has projected that 184,000 youth currently aged 0-17 in the state will die prematurely from smoking.[1,2] Each year, over 10,000 Georgians die from a tobacco-related death, resulting in more than 183,000 years of life lost which costs the state over $3.3 billion in lost productivity. [1,2] Additionally, CDC estimates that for each of these premature deaths caused by smoking, another 20 Georgians are living with a serious medical illness caused by smoking.[3] Together these premature deaths and over 200,000 Georgians living with serious illnesses caused by smoking result in over $1.8 billion healthcare costs each year. But the disease, death, and economic burden from tobacco use can be reduced by funding a comprehensive tobacco control program based upon the CDC recommendations.

Even though Georgians smoke at about the same rate as the national average, Georgians suffer disproportionately from tobacco-related diseases. Approximately 90 percent of lung cancer is caused by tobacco smoke and Georgia's lung cancer death rates are substantially above the national average. In fact, lung cancer is the leading cause of cancer deaths, killing more Georgians than breast, colon, prostate and pancreatic cancer combined. At the same time tobacco use is taking a deadly toll on Georgia citizens, scientific understanding of ways to reduce tobacco use has greatly advanced. Over the last ten years, rigorous scientific studies have unequivocally demonstrated that a state investment in evidence-based tobacco interventions will not only reduce tobacco use, but will also reduce the burden of diseases caused by smoking, and most recently have shown an actual reduction in overall health care expenditures of approximately 7 percent.

While the evidence is accumulating that investment in tobacco control programs reduces smoking, disease and costs, the commitment to tobacco control has declined by over 90 percent over the last few years, despite the fact that Master Settlement Agreement funding has increased. Given these facts, the Director of the Division of Public Health requested Georgia State University's Institute of Public Health to establish a Tobacco Task Force to make recommendations on the appropriate level of funding for tobacco control and to suggest an expenditure plan. During August of 2008 a Task Force was assembled consisting of representatives from federal, state and local health agencies, voluntary associations, non-profit advocacy groups and academic partners to review the current literature and to make recommendations for approximately $20 million of Master Settlement Agreement funding. The Task Force provides these recommendations in the following pages and notes that a $20 million investment is substantially less than the $116.5 million investment recommended by CDC, but represents an amount that will dramatically advance tobacco control efforts in Georgia and will result in demonstrable reductions in tobacco use.

Following the CDC guidelines, the Task Force recommends the following level of expenditures for tobacco control in Georgia:

Specific Programs	Recommended Budget (in millions)
State and Community Interventions	$ 8.5
Health Communication Interventions	$ 4.5
Cessation Interventions	$ 4
Surveillance and Evaluation	$ 2
Administration and Management	$ 1
Total	**$ 20**

In addition to detailing the optimal way of investing $20 million to reduce tobacco use in Georgia, the Task Force also made three policy recommendations for further accelerating the reduction of tobacco use in the state and that would position Georgia as a public health leader among Southern states. Specifically, the Task Force recommends:

1. Increase the cigarette excise tax by $1 to a total of $1.37, consistent with the recommendations of the Georgia Cancer Plan.
2. Provide nicotine replacement therapy for Medicaid patients and utilize the Federal match that is being used by 43 other states.
3. Strengthen the current Clean Indoor Air law to prohibit smoking in all public places, assuring clean indoor air for the approximate 10% or restaurants and bars that continue to allow smoking.

The Task Force is convinced that a major financial investment in tobacco control that builds upon the scientific evidence established over the last 10 years will result in a demonstrable reduction in tobacco use, tobacco deaths and health care expenditures. The success of the program is not only dependent upon a significant financial investment, but also upon strong leadership within the state, and a competent and accountable management structure. Georgia has the expertise in the state to establish an exemplary model program and one that will serve as a model for other southern states. It is our hope that the recommendations provided in this report will advance Georgia's effort to protect the health of the public in a scientific and cost effective manner.

BACKGROUND

The Health and Economic Burden of Tobacco Use in Georgia

Approximately 1.3 million adults in Georgia smoked cigarettes in 2007, with high rates of use found among those with less than a high education and those living in rural counties in the northwest and southeast regions of the state. In Georgia, 59% of current adult smokers tried to quit smoking in the past year; however national data shows that only about 4.7% of people who make a quit attempt maintain abstinence for at least 3 months.[2] In Georgia each year, 10,000 adults die and 183,000 life years are lost due to tobacco-related diseases, including several cancers (40% of deaths), cardiovascular disease (35% of deaths), and respiratory disease (25% of deaths).[6] Of all diseases, lung cancer accounts for greatest percentage (79%) of all tobacco-related cancer deaths in Georgia, with African-American men having higher mortality rates and African-American women being diagnosed with more new cases of lung cancer than their white counterparts.[6] The fact is more Georgians die from lung cancer caused by smoking than from breast, colon, prostate, and pancreatic cancer combined. Additionally, CDC estimates that for each of these premature deaths caused by smoking, another 20 Georgians are living with a serious medical illness caused by smoking.[3] Reducing the burden of cancer in Georgia cannot be accomplished without reducing tobacco use.[4]

Tobacco use is also a significant public health concern for young people in Georgia. Approximately 18,000 middle school and 73,000 high school students smoked in 2006, and their non-smoking peers are disproportionately exposed to secondhand smoke. If current patterns of smoking are not reduced in Georgia, CDC has projected that 184,000 youth currently aged 0-17 in the state will die prematurely from smoking.[1,2] While the majority has expressed an interest in quitting, very few middle (4%) and high (10%) school smokers have participated in a program to help them quit using tobacco at some time in their lives. Among nonsmoking youths, over a third of middle and nearly half high school students were reportedly exposed to secondhand tobacco smoke in the home.[5] Similar to adults, Georgian youth face a wide range of health consequences as a result of direct tobacco use or exposure to secondhand smoke, including respiratory illnesses (impaired lung growth, asthma, chronic coughing, and wheezing), ear infections, and premature death. Evidence from a large number of states has documented that when adequately funded, statewide tobacco prevention and control programs reduce rates of youth starting to smoke, adults successfully quitting, and nonsmokers exposed to secondhand smoke.[13-15]

In addition to health burden, tobacco use significantly contributes to economic burden in the state of Georgia. Together these premature deaths and over 200,000 Georgians living with serious illnesses caused by smoking result in over $1.8 billion healthcare costs each year and $3.3 billion in lost productivity costs. The estimated annual household state and federal tax burden from smoking-related government expenditures is $538. But the disease, death, and economic burden from tobacco use can be reduced by funding a comprehensive tobacco control program based upon the CDC recommendations. The research evidence has shown that the more a state invests in a comprehensive tobacco control program, the greater the reductions in youth and

adult smoking rates, and that the longer this investment is maintained, the greater and faster the impact is seen.[13-15] Without state-based funding, tobacco use can potentially contribute to significant health burdens for youth, the less-educated, certain racial/ethnic minorities, and some rural communities in Georgia and statewide economic hardship in terms healthcare costs and lost productivity.

Evidence-Based Tobacco Control Strategies

The tobacco epidemic could be stopped. Evidence-based, statewide tobacco control programs that are comprehensive, sustained, and accountable have been shown to reduce smoking rates, tobacco-related deaths, and diseases caused by smoking.[8,9]

Independently, the Office of the Surgeon General, the U.S. Task Force for Community Preventive Services, the National Cancer Institute, the Institute of Medicine, and the President's Cancer Panel have each published recommendations supporting the importance and effectiveness of comprehensive tobacco prevention and control programs and policies.[7, 10-13] In addition, the IOM's Committee on Reducing Tobacco Use concluded that to be effective, "states must maintain over time a comprehensive integrated tobacco control strategy."[11] Their lead recommendation was that each state fund tobacco control activities at the level recommended by the CDC, with the estimate that a state's reasonable target was in the range of $15 to $20 per capita, depending on the state's population, demography, and prevalence of tobacco use.[11] For Georgia, the CDC recommended annual investment is $12.44 per capita or $116.5 million in 2007 dollars.[9]

Multi-component intervention efforts that integrate programs and policy show greater effectiveness in influencing social norms, systems, and networks. The more states spend on sustained comprehensive tobacco control programs, the greater the reductions in smoking—and the longer states invest in such programs, the greater and faster the impact.[14-16] Additionally, a dose-response relationship exists between support for comprehensive programs and behavior outcomes. States that have made larger investments in comprehensive tobacco control programs have seen cigarette sales drop more than twice as much as in the United States as a whole, and smoking prevalence among adults and youth has declined faster as spending for tobacco control programs increased.[14-16] California, for example, has demonstrated that their state program spent $1.8 billion but saved $86 billion in personal healthcare costs in its first 15 years.[23] The savings were formulated by projecting that 3.6 billion packs of cigarettes (worth $9.2 billion to the tobacco industry) between 1989 and 2004, the implementation period of the California Tobacco Control Program.

The states with the best funded and most sustained tobacco prevention and control programs have been shown to increase the number of smokers quitting and to decrease the number of youth who start smoking. The Partnership for Prevention ranks tobacco use screening and interventions as one of the three most effective, cost-saving clinical preventive services.[22] In California, the sustained program has resulted in a significant decline in cigarette consumption that has been associated with a $86 billion lower level of health care expenditures from 1989 to 2004.[23]

Georgia Tobacco Control Funding: The Past and Present

Historical Perspective

The mission of the Tobacco Use Prevention Program (TUPP) within the Georgia Division of Public Health is to coordinate strategies for tobacco use prevention and control, provide assistance on policy development, and serve as a resource center for tobacco issues. The program adopted the national philosophy of changing environmental factors to reduce tobacco use.

Prior to the Master Settlement Agreement (MSA) in 1998, the Georgia Division of Public Health (DPH) established the building blocks for a broader and more comprehensive tobacco prevention and control program. DPH has been directly involved in tobacco use prevention and control activities since 1990, when a nicotine patch cessation effort was conducted in county public health clinics. Shortly afterwards, DPH received both a Centers for Disease Control and Prevention (CDC) Project IMPACT tobacco use prevention program planning grant and a Robert Wood Johnson Foundation (RWJFF) capacity-building award. These two grants formed the core of the Division's Tobacco Use Prevention Program (TUPP).

The CDC and RWJF funding spurred the development of the statewide tobacco prevention coalition, CHARGe (Coalition for a Healthy and Responsible Georgia), formed in 1993. By the time MSA funding was attained, CHARGe had grown to 14 program and policy partners and a network of over 500 organizations and individuals at both the state and local levels. In addition, several local CHARGe coalitions emerged furthering the overall state effort. CHARGe was initially housed within DPH. In December 1996, the Southeast Division of the American Cancer Society (ACS) became the lead agency for the Georgia Robert Wood Johnson Smokeless States grant, and assumed fiscal and management responsibility for CHARGe. DPH and ACS formed the backbone for CHARGe efforts as the coalition expanded. The coalition served as a forum for developing and carrying out strategies that focus on protecting people from secondhand smoke, preventing tobacco use among youth, and encouraging people who smoke to quit. CHARGe's focal policy areas were: smoke-free indoor air; preventing youth access to tobacco products; increasing excise tax on tobacco products; and reducing the advertising and promotion of tobacco products. Shortly after its establishment, CHARGe embarked on a major youth initiative creating Youth In CHARGe (YIC) in 1996. This was a collaborative effort of CHARGe, Egleston Children's Healthcare (now Children's Healthcare of Atlanta) and ACS.

In 1998, with the MSA, more funds became available for tobacco prevention and control efforts. CDC funding increased beyond planning grant levels and American Legacy Foundation, funded by the MSA, began awarding grants. Activities expanded to include surveillance and evaluation, counter-marketing, community interventions in four local public health districts, and program policy efforts. Six more health districts were added to the community intervention component in 1999, expanding intervention activities to a total of 30 communities, in 10 health districts.

DPH worked closely with the American Cancer Society, to develop the Youth In CHARGe (YIC) initiative, funded by the American Legacy Foundation for a five-year period beginning in 2000. YIC was a statewide network of middle and high school youth teams formed in schools and other community-based organizations throughout Georgia working on tobacco use prevention issues. Over 50 YIC teams were established across the state to create tobacco-free generations by changing peer pressure and attitudes toward tobacco by: eliminating exposure to secondhand smoke; preventing youth from using tobacco; reducing youth access to tobacco products; and fighting tobacco industry marketing tactics through education, mobilization, and youth empowerment.

Beginning July 2001, the first appropriation of state MSA funds was made to the Georgia Tobacco Use Prevention Program totaling almost $15.8 million. The largest portion, over $5 million, was dedicated to counter-marketing. Additional funds were allocated to community and school programs ($2.9 million), a Quit Line ($2.25 million), surveillance and evaluation ($800,000), as well as statewide training, technical assistance, and consultation, and overall support of best practice strategies at the state level. Tobacco prevention and control efforts were embedded in a broader health promotion initiative focused on healthy behaviors. This was due to the recognized relationship of risk factors such as physical inactivity, poor nutrition, and tobacco use to the development of a number of chronic diseases. With this funding, activities were extended statewide into every health district, each of which was able to engage staff to guide specific community tobacco interventions, as well as a more comprehensive chronic disease prevention effort.

Funding at this level was maintained over a four-year period, State Fiscal Years 02-04. After the initial year, MSA funding increased to $20.8 million, which provided for a comprehensive, statewide tobacco prevention program. With the downturn in the economy, following 9/11, funding was reduced to $14.7 million, with a further reduction in SFY 04 to $11 million. In SFY 05 changes in the legislative agenda reduced the appropriation to $2 million where it has remained.

The Present

The $2 million core MSA funding has enabled TUPP to maintain the Quit line and support minimal local tobacco prevention activities. In addition to MSA funds, TUPP receives $1.2 million from CDC to address the four goal areas of the tobacco prevention framework ($967,000) and a Quit Line supplement ($230,000). Georgia currently lacks the capacity to implement a comprehensive tobacco control program. This can be seen in the absence of a local advocacy structure to build on successes such as the Georgia Smoke-Free Air Act of 2005. Also lacking is a concerted prevention effort to address youth initiation, including counter marketing. Health promotion activities, which drove calls to the Quit Line, have been radically reduced. Quit Line call volume has dropped from a high of almost 23,000 at maximum funding to about 3,000 at current funding. Local staff that could devote full time efforts to tobacco prevention has decreased from 47 tobacco use prevention coordinators, to only 18 health promotion coordinators that are responsible for not only tobacco but also broader chronic disease health promotion activities.

Despite these challenges, adult tobacco use prevalence in Georgia has dropped from 24% (above the national average) in 2000, to 20% in 2007, which is below the national average. Some highlighted accomplishments include:

- Increase in excise tax on tobacco products from 12 cents to 37 cents
- Passage of the Smoke Free Air Act of 2005 prohibiting smoking in many public places.
- Imposition of tobacco surcharge for all state health benefit plan enrollees who use tobacco products.
- Adoption of 100% tobacco free school policies by 29 of 181 school systems.
- Inclusion of youth cessation services as a part of the Georgia Tobacco Quit Line.
- Launch Nicotine Replacement Therapy pilot in five high prevalence health districts.

RECOMMENDED PROGRAMS AND POLICIES

Programs

As the nation has addressed tobacco use over past 45 years since the release of the landmark Surgeon General's report, comprehensive, sustained, and accountable tobacco control programs have been shown to reduce smoking rates, tobacco related deaths, and diseases caused by smoking. Research shows that the more states spend on comprehensive tobacco control programs and the longer they sustain the investment, the greater and faster the impacts are on reducing tobacco use. CDC recommends an estimated $116.5 annually to mount such an effort in Georgia.

State and Community Interventions ($8.5 million)

State experience has shown that state- and community-based interventions are the core of a tobacco control program. In the evidence-based review of population-based tobacco prevention and control intervention strategies, the Task Force on Community Preventive Services found the strongest evidence demonstrating the effectiveness of the most highly recommended strategies came from studies in which the interventions were integrated into synergistic and multi-component efforts.[10] Building upon this evidence base, CDC recommends that tobacco control programs integrate statewide and local programs and policies for the general population and specific audiences, and reinforces grassroots support for social norm change.[9] To prevent and reduce tobacco use, CDC recommends implementing population-based interventions with coordinated statewide efforts, community mobilization, a focus on identifying and eliminating disparities, and integration with youth and other chronic disease programs.

Comprehensive tobacco control programs should provide sufficient support for a community-based infrastructure through activities such as: funding for local health departments and community-based organizations, coalition building, strategic planning, providing education and promoting public discussion around effective policy interventions, and collaborating with other public health programs. When programs are funded at less than the CDC recommended level, state experience indicates that the efficiency of program impact can be increased by emphasizing the policy and social change aspects of these efforts.[9,17-19]

Specific recommendations are:

I. Establish a mini-grant initiative. The goal of this program would be to provide funding to communities within the state to develop and strengthen collaborative, grassroots partnerships that focus on reducing tobacco utilization. An advisory board would establish the grant award parameters and criteria.
II. Increase the number of school systems that adopt and implement 100% tobacco-free school policies. Increase excise tax on all tobacco products.
III. Allocate funding to local community organizations to address social norms and behaviors related to tobacco use, thereby creating and fostering a nonsmoking culture.
IV. Develop statewide initiatives that address tobacco-related health disparities.
V. Expand access to cessation programs and services.

Health Communication Interventions ($4.5 million)

Effective messages that are targeted appropriately can stimulate public support for tobacco control interventions and create a supportive climate for policy and programmatic community efforts and effectively lead to sustained social norm changes.[9, 10, 20, 21] However, to be effective, health communication interventions must have sufficient reach, frequency, and duration to increase awareness, impact attitudes, and ultimately influence behavior. Additionally, state programs should include audience and market research, grassroots promotions and media advocacy, evaluation, and promotion of the state's Quit Line service.

Based upon the relative cost of implementing paid televised media in the state of Georgia, CDC recommends that $2.62 per capita be budgeted for a comprehensive health communication intervention that would promote cessation, prevention initiation, and educate the public about the importance of protecting nonsmokers from secondhand smoke exposure.[9] However, when less than the total annual recommended funding is available, the latest evidence-based recommendations emphasize the importance of more efficient use of broadcast media and greater emphasis on media advocacy and local grassroots efforts.

Specific recommendations are:

I. Augment and support the existing Georgia Tobacco Quit Line promotion, specifically by promoting increased access to and usage of the Quit Line. These efforts would include, but are not limited to: 1) utilizing frontline healthcare professionals to promote patient access to the Quit Line and 2) strengthening medical and other professional organization partnerships to enhance dissemination of tobacco cessation quit line resources.
II. Enhance support of Tobacco Free Schools through youth advocacy initiatives. The hallmark of youth advocacy is that school-age children champion tobacco prevention message development and dissemination. The initiative would include the use of innovative and contemporary communication technologies (e.g., instant messaging, on line social networking) to promote

advocacy to Georgia youths. Evidence suggests that the use of various types of media is very effective in promoting anti-tobacco campaigns.[25] The use of these communication technologies appeal to youth and would provide an innovative and effective anti-tobacco advocacy campaign.

III. Strengthen and Promote Clean Indoor Air initiatives. Reinforce communication to worksites and public places that Clean Air legislation is enforceable by law.

IV. Encourage health communications that foster a broad culture of 'health' within communities. Messages would touch upon various dimensions wellness, such as physical activity, clean air, etc

Cessation Interventions ($4 million)

Helping current tobacco users quit is critical to reducing the risk of premature death and disability, short-term health care costs, and influencing social norms.[9-13] All patients that are seen in the health care system should be screened for tobacco use, receive brief interventions to help them quit, and be offered more intensive counseling services and FDA-approved cessation medications.

When the CDC recommended annual funding is available, states should budget for 6% Quit Line enrollment with a two-week course of NRT for insured callers and a four-week course of NRT to callers without insurance.[9] However, when less than the CDC recommended funding is available, this effective service often needs to be limited in availability to increase the overall efficiency of program efforts since the cost-effectiveness of quit attempts resulting from price increases and smoke-free policies is much greater.[21]

Specific recommendations are:

I. Augment quit line capacity. The quit line is the cornerstone of cessation interventions and has demonstrable effectiveness. As of 2006, 27% of callers to the Georgia Tobacco Quit Line had not smoked at all within the past 30 days, consistent with other statewide telephone counseling services reported quit rates.[5]

II. Expand Nicotine Replace Therapy [NRT] support for disparate populations. Georgia is 1 of 7 states with no coverage for NRT. Smoking rates are higher among Medicaid recipients, and in Georgia, 3-4% of the Medicaid population takes advantage of NRT. Provision of Medicaid coverage would increase call volume to the Quit Line.

III. Promote adoption and implementation of brief cessation counseling among health care providers. Link disease management programs to Georgia Tobacco Quit Line.

IV. Promote public and private health insurance coverage for cessation services.

Surveillance and Evaluation ($2 million)

A comprehensive tobacco control program must have a system of surveillance and evaluation that can monitor and document short-term, intermediate, and long-term intervention outcomes in the population to inform program and policy direction, as well as to ensure accountability to those with fiscal oversight. States are encouraged to bring on core surveillance activities early in program development. As a result, states working with budgets smaller than the CDC recommended level of investment may find that this component actually consumes a percentage of the total that is larger than 10%. This investment will assist states in establishing baseline data so that programs will be ready to initiate program activities when funding for interventions becomes available.

Specific evaluation recommendations are as follows:

I. Expand existing surveys (e.g., expansion of the Youth Risk Behavior Survey and the Georgia Youth Tobacco Survey) to collect data from smaller, local counties. For example, the YRBS and GA Youth Tobacco Survey are not currently administered statewide. Also expand existing surveys to collect data regarding Quit Line promotion.
II. Elicit qualitative data. Mixed methods of research yields rich insight which will inform future tobacco control opportunities.
III. Expand complexity of analysis. Financial, risk, disparity analysis contribute to a greater understanding of comprehensive tobacco control impacts.

Administration and Management ($1 million)

Internal capacity within a state health department is essential for program sustainability, efficacy, and efficiency. State experience has shown the importance of having all of the program's components coordinated and working together; a function that occurs through the Administration and Management line. The limited funding that CDC is able to provide for the 50 states and the District of Columbia is most commonly used to help sustain this critical component. Because sufficient capacity is essential to maintain program infrastructure, this level of investment remains the suggested budgeting target for administration and management activities even if actual program funding is below the CDC-recommended amount.

Specific administration and management recommendations are to:

I. Organize a state Advisory Committee to oversee comprehensive tobacco control plan development and implementation. Success of plan is contingent upon recognized leadership in clearly defining the scope of work and being accountable on every level of activity.
II. Augment personnel. Although the Task Force has recommended extensive expansion of tobacco control efforts, 8 new positions have been identified:

Personnel

- Mini-grant manager: administration of grassroots grant initiative
- Epidemiologist: analyze statewide, county-level and local surveys
- 6 regional tobacco specialists (charged with overseeing approximately 3 districts each): seize opportunities to collaborate with local health promotion coordinators

POLICIES

Medicaid Reimbursement of Smoking Cessation

In 2006, 5.82% of Georgia's Medicaid expenditures, totaling $537 million, were attributable to tobacco use. Currently, our Medicaid program covers no medications or counseling for their recipients to aid in quitting smoking. Georgia is one of only seven states that does not provide these life- and money-saving treatments to its Medicaid recipients. The 2008 update from the U.S. Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence*, recommends seven types of medication; as well as individual, group and telephone counseling; as effective in helping people quit smoking. The combination of counseling and medication is more effective than either alone. Covering cessation programs through Medicaid is particularly important because the Medicaid population smokes at a much higher rate (34.8%) than the general adult population (20.8%). Medicaid pays for nearly 40% of the nation's births. Reducing smoking among low-income mothers reduces the number of low birth-weight births and related complications. These cost-savings can be seen in just nine months. For every $1 spent helping a pregnant woman quit smoking, the state saves $3 in the short term and $6 in the long term. For every smoker that quits, savings in medical expenditures after one year total $192. After five years the savings rise to $986 per year. Georgia currently receives approximately $5 for every $3 invested in a Medicaid service. We urge state officials to invest in this service for our Medicaid population. In this instance, a little state spending can go a very long way.

Tobacco Tax Increase

The Georgia General Assembly should strongly consider increasing the excise tax on cigarettes by $1.00. An increase in the tax rate would be beneficial to the state on several levels. First, the $1.00 increase in the tax rate would generate an estimated $612 million annually for the State of Georgia. Georgia currently ranks forty-third in the nation with a tax rate of $0.37 per pack, missing out on a significant revenue stream. A small portion of the new revenue generated should subsequently be used to bolster the state's tobacco control program, which is currently funded at a level well below the most recent recommendations published by the Centers for Disease Control. Secondly, from a tobacco control standpoint, increasing the tax rate will reduce the smoking prevalence in Georgia. Studies indicate that for every 10% increase in the point-of-sale price of cigarettes, there is a corresponding 4% reduction in cigarette use in the general population.[4] This impact is intensified with respect to the adolescent population, a group often targeted by big tobacco marketing campaigns. Finally, by increasing the cigarette tax, the state will force individuals that make the choice to smoke to take responsibility for their actions by directly bearing the cost of their habit. The State of Georgia

spends $537 million annually through Medicaid in the treatment of smoking related illnesses.[4] The bottom line is that for many reasons, increasing the tobacco tax is an integral part of an effective tobacco control program in the State of Georgia.

Clean Indoor Air Law

In 2006, the Surgeon General issued a report: *The Health Consequences of Involuntary Exposure to Tobacco Smoke*. [24] The report revealed that:

1. Secondhand smoke (SHS) causes premature death in persons who do not smoke
2. Children exposed to SHS are at risk for asthma, SIDS, ear problems
3. SHS causes lung cancer and coronary heart disease
4. There is no risk-free level of exposure to secondhand smoke
5. Millions of Americans are still exposed to secondhand smoke in their homes and workplaces
6. Eliminating smoking in indoor spaces fully protects nonsmokers from exposure to secondhand smoke. Separating smokers from nonsmokers, cleaning the air and ventilating buildings cannot eliminate exposure.

In 2005 the Georgia Legislature passed the Georgia Smokefree Air Act of 2005 restricting smoking in most public places. While the law greatly improved the situation in Georgia, it still allowed restaurants and bars to allow smoking as long as children under the age of 18 were not admitted, and also under a number of other exceptions. These exceptions have resulted in less than complete protection from exposure to secondhand smoke for Georgians, particularly for bar and restaurant workers who continue to work in venues where smoking is still allowed. Research conducted by the Institute of Public Health found that approximately 10 percent of Georgia restaurants and bars still allow smoking and have no intention of changing their current practices. Since secondhand smoke is considered a Class A carcinogen by the Environmental Protection Agency and there is no safe level of exposure, the Task Force recommends the Georgia Smokefree Air Act of 2005 be strengthened so as to prohibit smoking in all indoor public areas without exception. Without a comprehensive law with strong enforcement, children, hospitality workers and the general public will continue to be involuntarily exposed to a real and measurable cancer risk.

BUDGET AND IMPLEMENTATION COSTS

The following chart presents the proposed tobacco prevention and education programs and the respective budgets. The proposed budget of $20 million is modest and well below the CDC recommended annual investment for GA of $116.5. This amount is less than what was spent 6 years ago; however, it represents a substantial improvement over current spending. Evidence from similar state-based tobacco control program has quantifiably demonstrated a 50:1 return on investments ratio in tobacco control to health care savings. In 2006, California's investment of $1.8 billon yielded a return of $86 billion in health care savings.

Specific Programs	Recommended Budget (in millions)
State and Community Interventions	$ 8.5
Health Communication Interventions	$ 4.5
Cessation Interventions	$ 4
Surveillance and Evaluation	$ 2
Administration and Management	$ 1
Total	**$ 20**

SUMMARY

Georgia has before it the unique opportunity to use funds intended to prevent tobacco use to save the lives of untold thousands of its citizens. Georgia citizens suffer a disproportionate burden from diseases caused by smoking and there are scientifically documented programs and policies that will reduce tobacco use, disease and associated health care costs. The Georgia Tobacco Task Force is recommending that a budget of $20 million for tobacco control be re-established in the state and that these funds be invested in evidence-based policies and programs as outlined by the Centers for Disease Control and Prevention. Based upon these CDC guidelines, Georgia needs to invest $166.5 million annually to fund all the components of a comprehensive tobacco prevention and control program at the level of population coverage recommended by CDC. Though the Task Force's recommended investment is substantially less than that of CDC, research has shown that states which invest at less than the CDC recommended level can still impact youth and adult smoking rates, albeit at a slower rate of change and a need for a maintained investment to achieve the projected impact on health care costs. With an investment of $20 million per year in Georgia, or about $2 per capita, an impact can be achieved and will place Georgia on the right path to permanently reduce tobacco use in the state and to serve as a model for other Southern states.

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