CHAPTER 2

Reducing Tobacco Use in the United States

A Public Health Success Story . . . So Far

Nancy R. Lee

Knowing is not enough; we must apply.
Willing is not enough; we must do.
—Goethe

In 1964, almost half (42%) of the adults in the United States smoked cigarettes. By 2007, that number had declined to 20% (CDC, 2007; IOM, 2007). And among youth, the prevalence of daily smoking among 12th-graders decreased from 23% in 1999 to 12% in 2006 (IOM, 2007). These near 50% declines have been characterized as one of the 10 greatest achievements for the United States in public health in the 20th century (IOM, 2007). The stories, strategies, and unfinished business for this public health hazard are covered in this chapter, with a focus on inspirational youth smoking prevention and adult cessation efforts.

UNITED STATES: A COUNTRY OVERVIEW

The United States of America is situated mostly in central North America and is comprised of 50 states plus Washington, DC, the capital district. The United States

also possesses several territories in the Caribbean and Pacific. At 3.8 million square miles (9.83 million square kilometers) and with more than 300 million people (*BBC News*, 2008), the United States is the third largest country in the world, by land area and by population. The major religion is Christianity, and it is one of the world's most ethnically diverse nations, the product of large-scale immigration from many countries. In terms of gross national product (GNP), it is the largest national economy in the world (*BBC News*, 2008).

The United States is fundamentally structured as a representative democracy, and the federal government is composed of three branches: legislative, executive, and judiciary. Politics in the United States have operated under a two-party system (currently, the Democratic and Republican parties) for virtually all of the country's history. The greatest challenges facing the country (judging by the 2008 presidential debates) include the war in Iraq, the economy, illegal immigration, health care, education, and the environment.

Life expectancy in the United States is 76 years for men and 81 years for women (*BBC News*, 2008). The following 10 current leading health indicators reflect the major public health concerns in the United States, chosen based on their ability to motivate action, the availability of data to measure their progress, and their relevance as broad public health issues: *physical activity*; *overweight and obesity*; *tobacco use*; *substance abuse*; *responsible sexual behavior*; *mental health*; *injury and violence*; *environmental quality*; *immunization*; and *access to health care*. Goals for each of these indicators have been established for 2010 and are used to help measure the health of the nation (Healthy People 2010, 2005).

The Tobacco Problem in the United States

Tobacco use is the single most preventable cause of death and disease in the United States. An estimated 21% of adults (45.3 million; CDC, 2007), 20% of high school students, and 6% of middle school students smoke cigarettes (CDC, 2009). Annually, cigarette smoking causes approximately 440,000 deaths, and for every person who dies from tobacco use, another 20 suffer with at least one serious tobacco-related illness (CDC, 2008). Astoundingly, approximately one in every five deaths in the United States is smoking related, accounting for more deaths than those from AIDS, alcohol use, cocaine use, heroin use, homicides, suicides, motor vehicle crashes, and fires combined (IOM, 2007).

And then there are economic costs. Estimates are that this addiction costs the nation more than $96 billion per year in direct medical expenses as well as more than $97 billion annually in lost productivity. Furthermore, there are the effects of exposure to secondhand smoke, costing the United States an additional $10 billion per year (CDC, 2008).

In terms of demographics, smoking among this nation's adults is highest among American Indians/Alaska Natives (32%) followed by African Americans (23%), whites (22%), Hispanics (15%), and Asians (10%); it is highest among those with only a general education development (GED) diploma (46%) and among adults living below the poverty level (31%; CDC, 2007).

Among youth, smoking is highest among whites (23%), followed by Hispanics (17%). Factors associated with youth tobacco use include low socioeconomic status, approval of tobacco use by peers or siblings, smoking by parents or guardians, accessibility and price of tobacco products, lack of parental support or involvement, and low levels of academic achievement. Studies also indicate that youth who smoke are more likely to perceive that tobacco use is the norm, lack skills to resist influences, have a lower self-image or self-esteem, and lack self-efficacy to refuse offers of tobacco. In addition, tobacco use in adolescence is associated with many other health risk behaviors, including higher-risk sexual behavior and use of alcohol and drugs (CDC, 2009).

Reducing Tobacco Use: Major Milestones and Strategies

In 1964, an Advisory Committee to the Surgeon General of the Public Health Service declared in a seminal report that "Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action" (IOM, 2007, p. ix). As described in *Ending the Tobacco Problem: A Blueprint for the Nation* (IOM, 2007), noteworthy milestones and strategies eventually contributing to this decline in the first decades following the 1964 Surgeon General's report include:

1964–1988: Initial milestones and strategies

- Initial public education publicizing frightening findings about tobacco's dangers.
- Advocacy by coalitions of voluntary health groups such as the American Cancer Society, American Lung Association, and American Heart Association.
- Pharmacological approaches to cessation.
- School-based prevention programs, sometimes as a part of alcohol or other substance abuse programs.
- American Medical Association testimonies before Congress regarding the dangers of tobacco use.
- Advertising policies including an early Federal Communications Commission (FCC) requirement that stations run one free counter-advertisement from health groups for every three cigarette commercials that they aired and a law in 1971 banning all cigarette advertising on television and radio.
- Warning labels progressing from "Warning: Cigarette Smoking May Be Hazardous To Your Health" to "SURGEON GENERAL'S WARNING: Smoking Causes Lung Cancer, Heart Disease, Emphysema, and May Complicate Pregnancy."

1988–2005: Progress once nicotine was declared an addictive agent

- A 1988 Surgeon General's report concluding that nicotine is an addictive agent, undermining the tobacco industry's position that smoking is a "free choice."
- Recognition that most smokers become addicted in their teens.
- U.S. Food and Drug Administration (FDA) control of cigarettes beginning in 1996, with new regulations limiting youth access and advertising targeting young people.
- States taking the lead in creating smoke-free spaces and new anti-tobacco coalitions in states beginning to affect important policy actions.
- The people of California passing Proposition 99, a referendum that increased the excise tax on tobacco from 10 to 35 cents per pack and earmarked 20 percent of the new revenues for a statewide anti-smoking campaign.
- State litigation, including the Master Settlement Agreement with the major tobacco companies that required companies to pay an estimated $206 billion to 46 states between 2000 and 2025 and to support a new charitable foundation—which became the American Legacy Foundation. (IOM, 2007, pp. 107–127)

Further Reductions in Tobacco Use: "A Blueprint for the Nation"

In 2007, the Committee on Reducing Tobacco Use presented 43 recommendations to achieve three distinct goals related to reducing tobacco use, published in *Ending the Tobacco Problem: A Blueprint for the Nation* (IOM, 2007, p. 3):

1. Reduce tobacco product use initiation.
2. Increase cessation.
3. Reduce exposure to environmental tobacco smoke.

This chapter focuses on two success stories—one related to the first goal of preventing initiation (the **truth® Campaign**) and the other to the second goal of increasing cessation (Washington State's **Quit Line**). More information on these 43 recommendations appears at the end of this chapter.

CASE STUDY 1
The truth® Campaign
Youth Tobacco Prevention: Empowering Teens With truth®

BACKGROUND, PURPOSE, AND FOCUS

truth®, launched in February 2000, is the largest national youth smoking prevention campaign in the United States and the only national prevention campaign not directed by the tobacco industry (see Figure 2-1).

The campaign was created by the American Legacy Foundation®, founded as a result of the 1998 Master Settlement Agreement between the tobacco industry and 46 states and 5 U.S. territories. The foundation's mission is to *build a world where young people reject tobacco and anyone can quit* (American Legacy Foundation, 2009). The campaign exposes the tactics of the tobacco industry, the truth about addiction, and the health effects and social consequences of smoking. The focus is on inspiring teens to make informed choices about tobacco use by giving them the facts about the industry and its products and tools to enable them to "take control."

FIGURE 2-1 **truth®** Campaign Logo
Courtesy of the American Legacy Foundation

Source: Information and insights for this case were contributed by Patricia McLaughlin, the Legacy Foundation's Assistant Vice President of Communication.

TARGET MARKET PROFILE

The target market for the campaign is youth aged 12 to 17 years old who are defined as "sensation seekers" and thus most open to smoking. Nearly 80% of smokers begin using tobacco before the age of 18, so it is critical to reach this audience before they take up smoking and face a potential life of tobacco-related disease or even death (Mowery, Brick, & Farrelly, 2000). In 1999, a year prior to the campaign's launch, an estimated 35% of youth in 9th, 10th, 11th, and 12th grades used tobacco one or more times in the past 30 days. Rates increased by age from 28% of 9th-graders to 43% of 12th-graders (CDC, 2009).

MARKETING OBJECTIVES

Marketing strategies were developed with the following objectives in mind:

- *Behavior objectives:* Influence youth not to smoke and to express their concerns with the strategies, tactics, and lies of the tobacco industry.
- *Knowledge objectives:* For youth to know that the tobacco industry targeted them and to know the facts about the health effects, social cost, addictiveness, and ingredients/additives.
- *Belief objectives:* For youth to believe that not smoking is a way to express independence and that smoking is not the norm; they are in control and empowered to make the choice.

BARRIERS, BENEFITS, AND THE COMPETITION

Many youth find it hard not to at least try smoking, and several factors influence their desire to experiment, including peer pressure, older siblings and/or parents smoking around them, stress, and natural curiosity.

Benefits they imagine or they may assume include looking older, looking sexier, reducing stress, controlling weight, being independent, fitting in, being respected, expressing themselves, and being a rebel or a risk taker.

The competition, of course, is the tobacco industry, and the billions of dollars a year Big Tobacco spends to make its products accessible, visible, and seemingly cool—especially to youth. Other anti-smoking messages in the past came from the tobacco industry, and it was found that exposure was associated with more positive attitudes toward the industry and increased intentions toward future smoking.

POSITIONING

In the end, campaign planners want youth to see that the Big Tobacco companies are trying to manipulate them. As described on **truth®**'s Web site, "We're not anti-smoker, or anti-smoking. We're just anti-manipulations. With that in mind, we try to 'out' Big Tobacco's tactics so everyone knows what they're up to." The campaign's emphasis is on honest facts and information about tobacco products and the tobacco industry and gives teens tools that enable them to take control and make informed decisions about tobacco use. As also described on the foundation's Web site, "The power of our industry manipulation positioning is not only positioning **truth®** as a value-based brand, but in repositioning Big Tobacco. Our brand is the truth. Their brand lied."

STRATEGIES

The **truth®** Campaign uses evidence-based research, research with teen audiences, marketing and social science research, and lessons learned from the most successful anti-tobacco campaigns to inform its strategies. In the following presentation of strategies, a few that were *not* a direct strategy of the **truth®** Campaign are also mentioned. They are considered companion strategies, because they also target the youth market with similar objectives and positioning. Several of those that are included are ones highlighted and recommended by the Committee on Reducing Tobacco Use, helping to illustrate

the use of the complete marketing mix in trying to achieve certain public health goals.

Product

- The *core product*, the benefit promised, is an opportunity for self-expression, healthy rebellion, and the health benefits of being a nonsmoker.
- The *actual product*, the desired behavior, is for youth to reject smoking.
- The *augmented product* includes a variety of opportunities for youth to express themselves, including sharing tobacco-related information with their friends through social networking sites and playing games that educate them about tobacco while entertaining and holding their interest.

Price

Although not a formal part of the **truth®** Campaign, the Committee on Reducing Tobacco Use says, "It is well established that an increase in price decreases cigarette use and that raising tobacco excise taxes is one of the most effective policies for reducing use, especially among adolescents" (IOM, 2007, p. 9). Although, of course, it is illegal in the United States for youth aged 12 to 17 to purchase cigarettes, increases in price have been a deterrent because such underage youth then have to pay others to purchase cigarettes for them.

Place

To illustrate the use of the "place" marketing tool, a recommendation from the Committee on Reducing Tobacco Use notes that a reasonably enforced youth-access restriction is an essential element of modern tobacco control. Age verification, as well as placing product displays behind the counter and banning self-service modes of access to tobacco work effectively to reduce youth access. The commission recommends, therefore, that (#11) all states should license retail sales outlets that sell tobacco products and (#12) all states should ban the sale of tobacco products directly to consumers through mail order, the Internet, or other electronic systems. Further, shipments of tobacco products should be permitted only to licensed wholesale or retail outlets (IOM, 2007, pp. 10–11).

Promotion

Messages

At the core of the **truth®** Campaign's promotional strategies are messages about the tobacco industry, as well as the health effects, social costs,

addictiveness, and ingredients/additives of tobacco. The style and tone are "in-your-face" and hard-hitting, responding to teens' desire for powerful messages that display courage and honesty in a forceful way. To ensure that **truth®** is relevant to teens, teens are involved in testing advertising concepts and are encouraged to provide suggestions and feedback through the **truth®** Web site at http://www.thetruth.com/.

Messages supporting knowledge and belief objectives have included:

- Sodium hydroxide is a caustic compound found in hair removal products. It's also found in cigarettes.
- Tobacco companies' products kill 36,000 people every month. That's more lives thrown away than there are public garbage cans in New York City.
- Human sweat contains urea and ammonia. So do cigarettes.
- Benzene, arsenic, and cyanide are all poisons. They're all in cigarette smoke, too (NCI, 2001).
- There are more than 5 million deaths worldwide from smoking each year (WHO, 2005).

Messengers

Clearly, the key messengers for the **truth®** Campaign are youth, appearing in most ads, on Web sites, sharing information through social networking sites, and sharing information at grassroots events throughout the country. The campaign is designed to be peer-to-peer, so many of the campaign's elements can be passed on and shared with friends.

Media Channels

truth® advertising reaches a broad audience with multicultural messages. The **truth®** Campaign is everywhere in youth media—on television networks popular with teens like MTV, BET, G4, The N, Fuel, VH1, and fuse. **truth®** plays in cinemas, in advertising before movies. **truth®** also has a prominent presence on the Internet with its highly interactive and relevant-to-teens Web site, www.thetruth.com, that allows teens to engage with **truth®** on their own terms, as well as profiles on popular social networking sites like MySpace, Bebo, and Hi5. Box 2-1 provides a chronology of **truth®** Campaign themes.

BOX 2-1 A Chronology of **truth®** Campaigns, 2000–2008

- **truth®** (2000) launched at a youth summit attended by 1,000 teens from across the country.
- *Infect* **truth®** (2001, 2002) educated teens on the facts about cigarette design and engineering.
- The *Daily Dose* (2001) campaign laid the groundwork for all the **truth®** ads to come. Raw, no-frills ads featured real youth holding up long LED screens displaying **truth®**-related facts, providing information so that teens could begin to make their own educated choices about smoking.
- A look behind the *Orange Curtain* (2002, 2003) shed light on the tobacco industry's marketing tactics and included such topics as addiction and the health consequences of smoking.
- *Crazyworld* (2003) showed teens how tobacco companies play by a different set of rules than other companies. While many companies recall products at the first sign of danger to a consumer, the tobacco industry makes a product that kills 1,200 of its customers every day.
- *Connect* **truth®** (2004) used an orange dot icon to link together pieces of information to reveal the larger picture about the effects of smoking and the chain of events involving tobacco–from marketing to consumer illness and death.
- *Shards O'Glass* (2004) featured a fictitious company that manufactures freeze pops with glass shards in them, a dangerous product analogous to cigarettes. The ad is meant to raise consumer awareness about the harmful effects of smoking.
- *Seek* **truth®** (2004) used the Q&A (question-and-answer) format to encourage teens to ask questions and seek answers about the tobacco industry and its marketing and manufacturing practices.
- *Fair Enough* (2005) took a new approach to advertising with a sitcom-style television campaign that featured a cast and theme music. The commercials used tobacco industry documents to reveal marketing ideas.
- **truth®** *found* (2005–2006) pointed big orange arrows at some of the people and places targeted and affected by Big Tobacco.
- **truth®** *documentary* (2006) used a documentary filmmaking style to capture real people's reactions to the marketing tactics of the tobacco industry. The campaign, called **truth®** *documentary* for the style in which the ads were shot, featured one correspondent and a camera crew investigating the reasoning behind some ideas from Big Tobacco.

(continues)

BOX 2-1 A Chronology of truth® Campaigns (continued)

- *Infect* **truth**® (2006 update) called attention to the marketing tactics and health consequences of the tobacco industry in such a way as to "infect" people with that knowledge and encourage active peer-to-peer participation. *Infect* marked the debut of **truth**® on popular social networking sites like MySpace.
- **truth**® *documentary phase II* (2007) built on the approach of **truth**® *documentary* to continue to highlight the absurdity of statements found in tobacco industry documents.
- *The Sunny Side of* **truth**® (2008) is a tongue-in-cheek, darkly humorous song and dance that takes on tobacco industry words and actions. The campaign unleashes animation, music, dancing, and cartoons to reveal the "sunny side" of tobacco use and the tobacco industry.

Web and Interactive Elements

Social media and new technologies play an important role in how today's teens live, play, and work. The **truth**® Web site, www.thetruth.com, has distinct interactive elements designed to engage and amuse teens, while sharing important information about tobacco use.

Applications on the site allow teens to interact with each other and share information related to tobacco and **truth**®. Regular features of the site include games; interactive polls related to facts about tobacco; embedded videos of current **truth**® TV ads; and such downloadable items as posters, computer desktop kits, desktop wallpaper, and buddy icons. For example, an animated feature called "The Useful Cigarette" allowed visitors to point and click at an animated cigarette to learn how ingredients found in cigarettes and cigarette smoke can also be found in common household products such as pest repellant, floor wipes, and nail polish remover.

In addition to the main Web site, **truth**® homepages on popular social networking sites carry items such as e-mail cards, downloadable wallpapers, buddy icons, and screen savers. Having a presence on the social networking sites allows **truth**® to spread its messages quickly and economically throughout the teen community. The impact of the social networking sites on driving traffic back to the main Web site has been substantial, with thetruth.com experiencing its best sustained traffic.

Cinema

Going to the movies continues to be a popular form of entertainment for teenagers. Beginning in 2007, **truth®** advertising began playing in movie theaters as commercials before movies—another effective way in which to reach the teen audience. In 2008, The "Sunny Side of **truth®**" campaign was seen in more than 1,500 Screenvision theaters on nearly 10,000 screens in 48 states.

GRASSROOTS OUTREACH

Summer tours across the country allow teens to engage firsthand with the campaign. Signature orange **truth®** "trucks" rigged with DJ decks and video monitors allow teens to speak and interact firsthand with **truth®** "crew members" at popular events and music festivals where teens gather. At each tour stop, crew members hold fashion shows, dance contests, freestyle rap "battles," and DJ lessons. The fun and engaging atmosphere makes it easier for **truth®** crew members to discuss tobacco issues in a non-preachy manner. Teens also walk away from these interactions with **truth®** "gear" items like T-shirts, bags, hats, and wallets. The gear subtly reinforces facts about tobacco and incorporates cool graphics and designs, creating sought-after items that teens are proud to wear.

In addition, the tour is heavily featured on thetruth.com Web site throughout the summer, allowing teens to meet **truth®** crew members and read the crew members' blogs, view updates from tour stops, and get free tickets. The latest tour, in 2008, reached more than 500,000 teens in more than 30 cities across the country (see Figures 2-2 and 2-3).

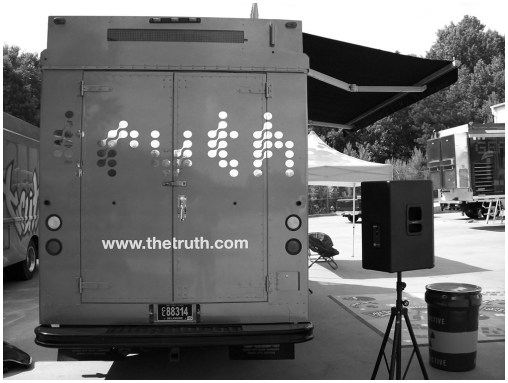

FIGURE 2-2 **truth®** Tour Truck
Courtesy of the American Legacy Foundation

FIGURE 2-3 Summer Tours Engage Teens Firsthand with the Campaign
Courtesy of Joshua Cogan and the American Legacy Foundation

BUDGET

The American Legacy Foundation—and the **truth®** campaign—receive the majority of their funding as a result of the Master Settlement Agreement (MSA), which required the major tobacco companies to pay $206 billion over 25 years to compensate U.S. states for the cost of treating citizens with tobacco-related diseases. The American Legacy Foundation was created out of an MSA mandate that a national charitable foundation be created with the mission to help "prevent diseases associated with the use of tobacco products in the states."

A National Public Education Fund provided approximately 74% of the foundation's overall funding through 2005. This means that approximately $300 million in annual payments from the settling states to the American Legacy Foundation's National Public Education Fund have been suspended, thus producing a "funding cliff" that has dramatically affected the size and scope of the foundation's lifesaving programs.

Spending for the **truth®** Campaign reached a high in 2001, when the promotional budget was between $90 and $100 million. For 2008, the total promotional budget fell to between $35 and $40 million. Although that sounds like a lot of money, in comparison to what the tobacco industry spends it is actually very little. According to the Federal Trade Commission (FTC), the tobacco industry spent more than $13 billion in 2005 to market and promote its products in the United States alone—about $36 million per day—roughly equivalent to **truth®**'s budget for the year. **truth®** can never match that level of spending, so it strives to break through and be more cutting edge in order to effectively reach teens. With declining budgets, **truth®** is always looking for mutually beneficial partnerships that allow the campaign to further extend its lifesaving work and reach more teens.

The U.S. Centers for Disease Control and Prevention (CDC) is now (as of 2008) a key partner in further extending the reach of the **truth®** Campaign. Through a three-year, $3.6 million matching grant from the CDC awarded in 2006, the campaign increased its advertising in 18 states and 41 cities, reaching a broader range of youth, including young people in rural and surrounding smaller communities that typically have less exposure to the campaign because of low cable television penetration. The CDC renewed its grant with the foundation for a second phase of **truth®** advertising, allowing even more rural teens to be exposed to **truth®** advertising. A second component of the grant funds youth prevention-related grants at the community level.

OUTCOMES

A growing body of research has proven the efficacy of **truth®**. Research has found that the **truth®** Campaign accelerated the decline in youth smoking rates between 2000 and 2004. According to research published online in February 2009 by the *American Journal of Preventive Medicine* (AJPM), **truth®** was directly responsible for keeping 450,000 teens from starting to smoke during its first four years. A second study released through AJPM in February 2009 found that the campaign not only paid for itself in its first two years, but also saved between $1.9 and $5.4 billion in medical care costs to society.

In addition, research released in September 2007 found that the **truth®** Campaign may also be changing teens' perceptions about how common smoking is among their peers. A study conducted by RTI International and funded by the American Legacy Foundation indicated that teens exposed to the **truth®** Campaign have a more accurate view of the number of their peers who smoke. Teens with less exposure to the campaign believed smoking was more common among people their age. The study, "Association Between National Smoking Prevention Campaigns and Perceived Smoking Prevalence Among Youth in the United States," appeared in the *Journal of Adolescent Health*. The finding is good news for the **truth®** Campaign, because teens' perception of peer smoking has been shown to predict future smoking.

According to an article published on January 22, 2008, in *Health Education Research*, teens who were exposed to the American Legacy Foundation's national **truth®** youth smoking prevention campaign were more likely to harbor negative feelings toward the tobacco industry and more likely to intend not to smoke. The study expanded on previous research published in the *American Journal of Public Health* in 2002, *Getting to the Truth: Evaluation of National Tobacco Countermarketing Campaigns*, that looked at a 10-month period of the campaign. This 2008 study looks at an extended period of three years in which more than 35,000 young people aged 12 to 17 were polled on their attitudes toward **truth®**. The 2002 study showed that after only 10 months, exposure to the **truth®** Campaign increased young people's anti-tobacco attitudes and beliefs. This result was borne out again in the new study, which found that teens aware of the **truth®** Campaign were nearly twice as likely to say they did not intend to smoke in the future. The data showed that approximately 70% of teens were aware of the campaign over the three-year period. As in the prior study, the 2008 study examined nine tobacco-related beliefs and attitude items, including such points as "cigarette companies lie," "not smoking is a way to express independence," and "taking a stand against

smoking is important to me." Exposure to the **truth®** Campaign was associated with steady, positive changes in attitudes, beliefs, and intentions to smoke.

In addition to proven research, the **truth®** Campaign has won more than 300 awards for advertising and public relations efficacy and has also been lauded by leading federal and state public health officials, the CDC, and the U.S. Department of Health and Human Services.

CASE STUDY 2
Washington State's Tobacco Quit Line

Like other states in the United States and consistent with the Centers for Disease Control and Prevention guidelines, Washington State is currently implementing a comprehensive tobacco control program with goals that include increasing cessation, preventing youth initiation, and reducing secondhand smoke exposure among the state's residents. A cornerstone of that program is the provision of a statewide toll-free telephone Quit Line, where any Washington resident may access trained counselors for tobacco cessation support. (See Figure 2-4.) National review panels have consistently recommended telephone counseling to help tobacco users to quit, and all states in the United States currently offer a tobacco quit line (Maher, Rohde, & Dent, 2007).

On November 14, 2007, the Washington Tobacco Quit Line, managed by the Washington State Department of Health, received its 100,000th call for help (Washington State Department of Health, 2008). This is the state's social marketing success story.

FIGURE 2-4 Quit Line Logo
Courtesy of Washington State Department of Health

BACKGROUND, PURPOSE, AND FOCUS

In 2000, there were an estimated 1 million adult tobacco users in Washington State. On November 15, 2000, the state launched a new service with a purpose to reduce this number and a focus on the estimated 70% (700,000) of smokers who had some desire to quit (Haase, 2002). As had been

demonstrated by other states, a quit line approach is *effective* for a variety of reasons: it is more *cost-efficient*, with phone counseling as effective as face-to-face counseling yet less expensive to provide; it is *free* and *easily accessible* to residents throughout the state; it is more *convenient*, with no appointment necessary or need to travel; it is *confidential*; it offers *tailored protocols* for specific populations; and it has been shown to approximately double the typical (do-it-yourself) abstinence rates (Haase, 2002).

TARGET MARKET

The Quit Line's true target market—those most likely to call—were (and still are) tobacco users, aged 18 and over, who have decided they want to quit, those in the contemplation and preparation stages in the stages of change model (Prochaska, Norcross, & DiClemente, 1995). They have probably tried to quit in the past and may be feeling defeated. In terms of demographics, those who smoke are likely to be lower income, are less educated, live in rural areas, and may be less likely to have access to cessation support through traditional healthcare systems (BRFSS, 2006).

In terms of size of the target market, Washington's ongoing Behavioral Risk Factor Surveillance System (BRFSS) suggests the market is big, with two-thirds (68%) of smokers typically reporting that they want to quit, half (54%) seriously planning to quit within the next six months, and a third (33%) planning to quit within the next 30 days (BRFSS, 2006).

OBJECTIVES

The behavior objective for the campaign effort was (and still is) simple. The action program managers want from tobacco users who want to quit is to call the Quit Line.

BARRIERS, MOTIVATORS, AND COMPETITION

Formative research using focus groups prior to campaign development identified barriers to calling, those concerns that might keep someone from picking up the phone. Unanswered questions for this new service were the biggest barriers: How much does it cost? Will it be anonymous? Who will I talk to? What do they know about quitting? How many times can I talk with them? Can I get patches, pills, or other medications? Several fears were also expressed: *stigma* ("Others will think

less of me"), *weakness* ("I should be able to do it myself"), *failure* ("If it works so great, I would have heard about it from other smokers"), and *judgment* ("If I called and didn't quit, I'd worry about what the person would think of me").

What might make smokers more likely to call? "Knowing what I am going to get when I call; knowing counselors are ex-smokers or have had experience with quitting; knowing the service would be free, friendly, and effective and tailored to me; and assurance that I can get ongoing support—not just a one-time call."

The greatest competition for this target market wanting to quit is trying to do it on their own. In addition, messages from others, often family members, who do not think they need to get help to quit smoking could keep them from picking up the phone.

POSITIONING

From these insights into barriers, motivators, and the competition, campaign planners crafted a positioning statement. "We want target audiences to believe that when they call the Quit Line, they will talk with counselors who will be empathetic and understanding of how difficult it is to quit. It has worked for others and is a better and easier option than trying to do it all by yourself." Importantly, planners did not (and still do not) want to make smokers feel bad, because they probably already have a heavy dose of guilt and feelings of helplessness.

Product

The Quit Line (1-800-QUIT-NOW, and in Spanish, 1-877-2NO-FUME) provides callers with a variety of services and information:

- One-on-one counseling and support from a trained specialist.
- A quit plan designed especially for each caller.
- Information about other resources, such as insurance benefits and additional programs available in local areas.
- Advice on designing a quit plan.
- Problem-solving ideas to help succeed.
- Skills to break old habits.
- Help deciding about products and medications that can help quitting be easier and more successful.
- Nicotine replacement therapy (patches, gum) for motivated quitters who are low-income or uninsured.
- Special services to help pregnant women quit smoking.

A free Quit Kit, which is mailed to those requesting one, is full of information on making a decision about quitting; getting ready to quit; knowing what to expect when quitting; coping with withdrawal symptoms and stress; and how to ask friends, family members, or co-workers for support.

Quit Line counselors have a bachelor's degree in health education, counseling, or a related field; are nonsmokers or ex-smokers with at least two years of abstinence; have previous experience with phone counseling, behavioral change programs, or addiction work; and participate in a rigorous initial orientation, as well as ongoing training.

Price

The Quit Line is a toll-free number, and there is no charge for the counselor. It is available for Washington residents, confirmed by the area code that shows up on the screen when the call is received, as well as the mailing address provided to the counselor for materials to be sent.

Place

Washington's Quit Line counselors are available for coaching seven days a week, from 5 a.m. to 9 p.m., with the exception of some major holidays when service begins at noon. A brief automated message thanks the caller for calling, mentions the call may be recorded for quality control purposes, and is then routed to a coach. After hours, callers can leave a message and a counselor will then return their call the next day. This accessibility is one of the most important advantages of a quit line, eliminating many of the barriers of traditional cessation classes such as having to wait for classes to form or needing to arrange for transportation. Quit lines are particularly helpful for people with limited mobility, as well as those who live in rural or remote areas. And due to their quasi-confidential nature, a phone service is more appealing to those reluctant to seek help in a face-to-face or group setting.

In addition, the Quit Line Web site, www.quitline.com, provides a downloadable worksheet for creating a quit plan, as well as a "Click to Call" button that prompts the user to enter his or her phone number and then receive a call back within five minutes. In addition, healthcare providers can refer a patient to the Quit Line by faxing them a form indicating the patient would like to be contacted by a Quit Line counselor, even what hours of the day would be most convenient.

Promotion

Messages were designed, messengers chosen, and media channels selected based on the target audience and the desired positioning, and are intended to highlight the product, price, and place.

Messages

Messages target those ready for action, apparent in this copy on the Quit Line Web site:

> Do you smoke cigarettes, cigars, or pipes? Chew tobacco? If you do and want to quit, or are thinking about it, the Quit Line is here to help. You may have tried quitting before. Maybe even more than once. Don't worry! That's why we developed the Washington State Quit Line. To help you successfully quit. The Web site provides tips to help you quit and all the information you need to know about calling the Quit Line. You can learn about Quit Line coaches who are ready to help you and hear a sample call. Check out the information below for phone numbers, hours and what to expect once you dial. After that, it's your call.

And brochure copy stresses the chances for success:

> Today more and more people are kicking the habit and quitting for good. You can be on your way to freedom by calling Washington's Tobacco Quit Line. New research shows that those who call the quit line double their chances of success.

Messengers

Key messengers include healthcare providers encouraging patients to call and Quit Line coaches assuring potential callers they understand and will help. Personal messages from counselors such as the following appear on the Web site as well:

> Tom: "I've been through the quit process and I can relate to it. It's rewarding to know I have an impact on people's lives. Callers say, 'Wow I didn't think of that. That really helps!' and it's nice to know I played a role in that. I just got off the phone with a guy who had been chewing and had successfully quit. He was so appreciative and just kept saying, 'I couldn't have done this without you!'"

> Merry: "I smoked for 25 years before I decided to quit. I understand how smokers feel and what it means to give up smoking, especially if you've been doing it for decades. That's why my most rewarding experiences have been helping long-time smokers. Some have smoked for more than 50 years! I draw on my experience and tell people that they have the ability to change, no matter how long they've been smoking."

Healthcare providers are important influencers as well, and those interested receive training and information about the Quit Line, as well as Quit Line wallet cards and brochures to give to patients.

Media Channels

A variety of media channels (including television, radio, print advertising, bar coasters, posters, postcards, transit ads, outdoor billboards, publicity, and the Web site) and grassroots targeting approaches (including flyers distributed at work sites, community colleges, and other community locations) are used to reach target audiences.

In June 2002, the Tobacco Program launched its first made-for-Washington advertising campaign promoting the Washington Tobacco Quit Line. A new television, radio, and print advertising campaign has promoted the Quit Line each year since this initial launch (see Figure 2-5).

In 2004, the campaign had the look and feel of an Alfred Hitchcock film. As reported in *The News Tribune* in Tacoma, Washington, "The anti-smoking spot starts with a woman who receives a telephone call at her office and encounters an eerie silence. Viewers see a cigarette on the other end of the telephone line. Next, while the woman drives in her car, she senses a presence. Viewers see a cigarette in the back seat, but the woman looks back and finds nothing. Finally, while the woman lies in bed, a cigarette appears frighteningly near her hand

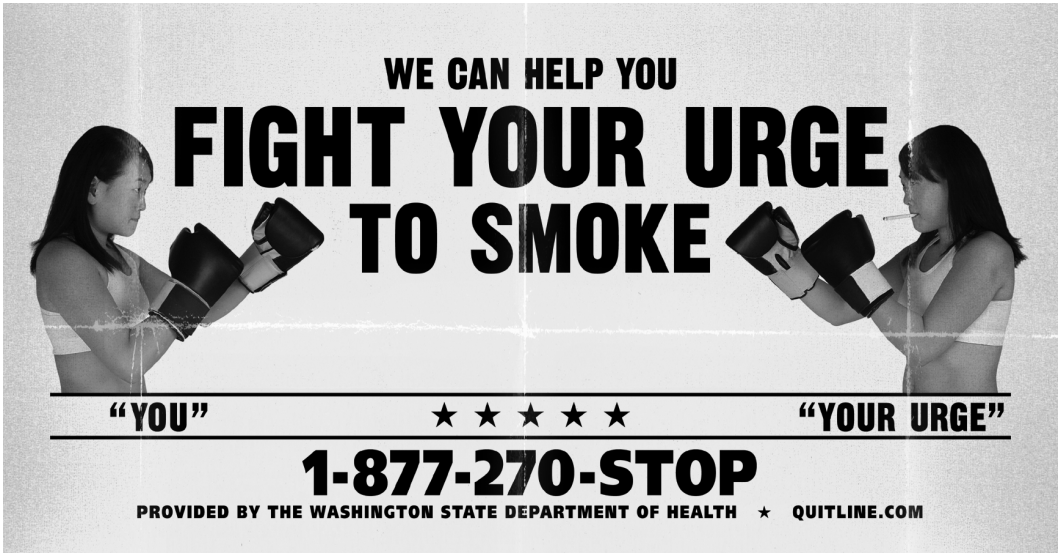

FIGURE 2-5 "Fight Your Urge to Smoke"
Courtesy of Washington State Department of Health

and she beats it to death with a shoe" (Voelpel, 2004). All to convince her, of course, that she can do it!

The latest campaign (2008) as this chapter was written, "Cold Turkey," emphasizes the importance of having a plan for organizing the quitting process. The star of the campaign is a real *cold turkey*, representing the difficulty of quitting "cold turkey" without a plan in place (see Figure 2-6).

In addition, the Tobacco Program hosts a Web site (Quitline.com) where visitors can listen to a sample call to the Quit Line, read stories from people who have quit tobacco, learn about the physical changes they can expect once they stop using tobacco, and meet some of the Washington Tobacco Quit Line specialists.

BUDGET

Funding for the Quit Line is from tobacco settlement dollars plus some enhanced funds from the Centers for Disease Control and Prevention (CDC) to run targeted promotions. The 2007–2008 budget for the service and promotion of the service was $2.8 million.

FIGURE 2-6 Graphic Image from 2008 Campaign Stressing the Need to Quit
Courtesy of David Emmite Photography

OUTCOMES

By 2006, the use of cigarettes in the state had decreased by approximately 24%, resulting in nearly 235,000 fewer smokers and moving the state to the fifth lowest prevalence of adult smoking in the nation—from 20th place in the year 2000. The Quit Line, launched in 2000, has certainly contributed to this outcome, receiving as mentioned earlier, its 100,000th call in November 2007 (Washington State Department of Health, 2007).

Profiles of Callers

An estimated 1% to 3% of Washington tobacco users have called the Quit Line, similar to overall national rates. Caller databases indicate that females are more likely to call than males (62% versus 38%), as well as those ages 41 to 50 (Haase, 2002; Quit Line, 2002). Telephone surveys conducted from October 2004 to October 2005 with Washington Quit Line callers shed light on additional demographics. Almost half of all callers (44%) were covered by private healthcare insurance or belonged to a health maintenance organization (HMO); a third (32%) received Medicaid; and a fourth (25%) were uninsured (Maher et al., 2007).

Quit Rates

Quit rate studies indicate that at six months, about 13% of callers have quit.

Hearing About the Quit Line

By 2006, nearly half of the smokers in the state had heard about the Quit Line (BRFSS, 2006), most commonly through television (37%), followed by a family member or friend (16%), healthcare provider (15%), or prior caller (12%), or through mention in the newspaper or magazine (6%; Quit Line, 2002).

Satisfaction With the Quit Line

A telephone survey with 356 callers, called back at two months after initial contact, indicated that the vast majority (86%) of callers were very or somewhat satisfied with the Quit Line; 87% were satisfied with their counselor; 89% with the materials they received; and 88% would recommend the Quit Line to a friend (Haase, 2002).

Cost-Effectiveness

Based on caller databases, telephone surveys, and budget records, the following costs were calculated; these can be used, in combination with expenditures, to determine a return on investment of resources:

- Estimated cost of the Quit Line service per Washington State smoker: $150.
- Estimated cost of the Quit Line per caller who made a serious attempt to quit: $140.
- Estimated cost of the Quit Line per caller who was tobacco free at six months: $830.

ADDITIONAL EVALUATION NOTES

Program managers for the Washington Quit Line offer a few additional insights for those considering adopting a similar service.

The Quit Line is most effective when used in combination with additional strategies, including tax increases, restrictions on smoking in public places such as restaurants and bars, and in combination with community-based activities such as recommendations from healthcare providers to call the Quit Line. They encourage others to advocate for cessation benefits to be included in health plans offered by employers to their employees, as well as by Medicaid and community health plans. Additionally, and though not formally tested, administrators have a "strong hunch" that offering a Quit Line and then having a highly visible campaign promoting it may help to "normalize" and increase quitting even among people who never call the line. After all, there are more than 25% fewer fellow smokers around in just seven years.

CONCLUDING NOTE: WE HAVE THE KNOW-HOW, BUT WILL WE DO IT?

Although much has been accomplished, the mission remains unfinished, with it unlikely that the United States will meet the Healthy People 2010 goal of 12% tobacco use for adults and 16% for high school youth (IOM, 2007, p. 124).

Concerns with waning momentum of tobacco control efforts and about declining attention to what remains the nation's largest public health problem, led the American Legacy Foundation (2004) to ask the Institute of Medicine (IOM) to

conduct a major study of tobacco policy in the United States. The IOM then appointed a 14-member committee and charged it to assess past progress and future prospects in tobacco control and to develop a blueprint for reducing tobacco use in the United States. To carry out its charge, the committee conducted six meetings in 2004 and 2005, at which the members heard presentations from individuals representing academia, nonprofit organizations, and various state governments. The committee also reviewed an extensive literature from peer-reviewed journals, published reports, and news articles. The committee found it useful to set some boundaries on its work concerning the goal of "reducing tobacco use" and the time frame within which it should be achieved. To make its task manageable and well focused, the committee decided to focus its literature review and evidence gathering on reducing cigarette smoking (IOM, 2007, p. 31).

As referenced earlier in the chapter, this blueprint was published in 2007 in *Ending the Tobacco Problem: A Blueprint for the Nation*, which included 42 recommendations in these three categories (IOM, 2007, pp. 12–13):

- 22 measures to strengthen traditional tobacco control.
- 18 measures to change the regulatory landscape.
- 2 new frontiers in tobacco control:
  - Congress should direct the CDC to undertake a major program of tobacco control policy analysis and development and should provide sufficient funding to support the program.
  - The FDA should give priority to exploring the potential effectiveness of a long-term strategy for reducing the amount of nicotine in cigarettes and should commission the studies needed to assess the feasibility of implementing such an approach.

In the end, the committee projected that the following specific policies, if implemented effectively and collectively, were likely help the United States reach the original Healthy People 2010 smoking prevalence target of 12% by about 2020, with a 10% prevalence by 2025. Marketing mix tool labels have been added to reinforce the strategic blend this effort will require:

- *Product:* Full coverage of pharmacotherapy and behavioral therapy, training and coverage for tobacco brief interventions, multisession quit lines, Internet interventions, and free nicotine replacement therapy.
- *Product:* Universal implementation of school-based prevention sufficient to cut the rate of smoking initiation by 10%.
- *Price:* Tax increases of $1 or $2 per pack (depending on current state excise rates).

- *Place:* Heavy enforcement of youth-access laws, accompanied by publicity and high penalties.
- *Promotion:* Comprehensive media campaigns targeting youth and adults and funded at the levels recommended by the CDC (i.e., beyond the levels that have been used in the past) to prevent initiation and to increase quit attempts, heighten consumer demand for proven cessation programs, and increase smokers' health literacy about the value of using evidence-based treatments when trying to quit.

QUESTIONS FOR DISCUSSION

1. What component of the marketing process or element of the marketing mix do you think contributed most to the **truth®** Campaign's success?
2. What other factors and efforts do you think (or imagine) have also contributed to reduction in youth tobacco use in the United States?
3. For the Quit Line, several barriers were noted. What specific features of the product (Quit Line) addressed these barriers?
4. How would you go about calculating a rate of return on the Quit Line? What other data would you need?

REFERENCES

American Legacy Foundation. (2004). http://www.americanlegacy.org/

BBC News. (2008). Country profile: United States of America. Retrieved July 28, 2009, from http://newsvote.bbc.co.uk/mpapps/pagetools/print/news.bbc.co.uk/1/hi/world/americas/country_profiles/1217752.stm

Behavior Risk Factor Surveillance System (BRFSS). (2006). Behavior Risk Factor Surveillance System Adult Cigarette Use for Washington State. Atlanta, GA: Centers for Disease Control and Prevention (CDC).

Centers for Disease Control and Prevention (CDC). (2007). Fact sheet: Adult cigarette smoking in the United States: Current estimates. Retrieved July 28, 2009, from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5745a2.htm

Centers for Disease Control and Prevention (CDC). (2008). Morbidity and mortality weekly reports: Smoking & tobacco use. Retrieved March 19, 2009, from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5745a3.htm

Centers for Disease Control and Prevention (CDC). (2009). Fact sheet: Youth and tobacco use: Current estimates. Retrieved July 28, 2009, from http://www.cdc.gov/tobacco/data_statistics/fact_sheets/youth_data/tobacco_use/index.htm

Haase, T. T. (2002). *Effectiveness of the Washington Tobacco Quit Line*. Paper presented at the Joint Conference on Health, Wenatchee, WA. Retrieved July 28, 2009, from http://www.doh.wa.gov/tobacco/data_evaluation/Assessment/presentations/quit_line_final.pdf

Healthy People 2010. (2005). *Leading health indicators*. Retrieved July 28, 2009, from http://www.healthypeople.gov/Document/HTML/uih/uih_4.htm

Institute of Medicine (IOM). (2007). *Ending the tobacco problem: A blueprint for the nation*. Washington, DC: National Academies Press.

Maher, J. E., Rohde, K., & Dent, C. W. (2007). *Is a statewide tobacco quit line an appropriate service for specific populations?* Retrieved July 28, 2009, from http://www.tobaccocontrol.bmj.com/cgi/content/abstract/16/Suppl_1/i65

Mowery, P. D., Brick, P. D., & Farrelly, M. C. (2000). Legacy first look report 3. *Pathways to established smoking: Results from the 1999 National Youth Tobacco Survey*. Washington, DC: American Legacy Foundation.

National Cancer Institute (NCI). (2001). Risks associated with smoking cigarettes with low machine-measured yields of tar and nicotine. *Smoking and Tobacco Control Monograph* 13, 1–236.

Prochaska, J. O., Norcross, J. C., & DiClemente, C. C. (1995). *Changing for good*. New York: Avon Books.

Quit Line. (2002). Adult tobacco telephone survey. Quit Line caller database, July 2001–June 2002.

Voelpel, D. (2004, December 5). Adman hopes to do for smoking what Hitchcock did for showering. *The News Tribune* (Tacoma, Washington), p. D1.

Washington State Department of Health. (2007). *Washington tobacco facts, January 2007*. Retrieved July 28, 2009, from http://www.doh.wa.gov/Tobacco/other/07tobfacts-public.pdf

Washington State Department of Health. (2008). *Washington Tobacco Quit Line receives 100,000th call for help.* Retrieved July 28, 2009, from http://www.prnewswire.com/cgi-bin/stories.pl?ACCT=104&STORY=/www/story/11-14-2007/0004705649&EDATE=CBE/CSE Style:

World Health Organization (WHO). (2005). *Why is tobacco a public health priority?* Retrieved July 28, 2009, from http://www.who.int/tobacco/health_priority/en/index.html