Reexamining the Pathways to Reduction in Tobacco-Related Disease

*Robert L. Rabin**

Six years ago, when I last wrote on tobacco policy, my perspective was to offer an assessment of the strengths and weaknesses of a half-century of tobacco control strategies aimed at reducing the health risks associated with cigarette smoking. I began with a discussion of informational strategies; then turned to public place restrictions; and followed with a treatment of excise tax initiatives. In my view, restrictions on advertising and promotion and resort to tort litigation had been less effective as control efforts, but nonetheless also warranted consideration. In the ensuing years, there have been a number of significant developments that have altered the course of tobacco control policy. Prominent among these developments has been the authority granted to the Food and Drug Administration in the Family Smoking Prevention and Tobacco Control Act of 2009; the resort by the industry to litigation in a new guise — particularly reliant on the First Amendment — as an offensive weapon targeting regulatory controls; and the publication of the 2012 Surgeon General's Report on youth smoking, which makes the case for top-priority attention to underage smoking behavior. These and related measures point to new pathways for breaking through a perceived recent loss of momentum in achieving further reductions in tobacco-related disease, without abandoning what has worked in the recent past. I attempt to pull together these multiple fronts in a Section focused primarily on youth smoking, assessing the promise of present efforts to reduce the harms associated with tobacco. Finally, I offer some brief thoughts from a broader public-health perspective, discussing the framework of tobacco control initiatives from the vantage point of the obesity problem.

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* A. Calder Mackay Professor of Law, Stanford Law School. My appreciation to Alexandra Moss for valuable research assistance, and to Kevin Schroth and Peter Schuck for helpful suggestions.

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Introduction

Six years ago, when I last wrote on tobacco policy, my perspective was to offer an assessment of the strengths and weaknesses of a half-century of tobacco control strategies aimed at reducing the health risks associated with cigarette smoking.[1] The most salient of these initiatives fell outside the traditional command-and-control/tort litigation tandem that frequently forms the core of systemic efforts to curb health and safety risks. I began with a discussion of informational strategies, commencing with the Surgeon General's Report of 1964;[2] then turned to public place restrictions (beginning in the mid-1980s); and followed with a treatment of excise tax initiatives. In my view, restrictions on advertising and promotion and resort to tort litigation (the latter, of course, primarily in the privately-initiated common law sphere) had been less effective as control efforts, but nonetheless also warranted consideration.

In the ensuing years, there have been a number of significant developments that have altered the course of tobacco control policy and underscored the dynamic nature of government/industry interaction in this critical public health arena. Prominent among these developments has been the emergence of a stronger federal presence under the authority granted to the Food and Drug Administration in the Family Smoking Prevention and Tobacco Control

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1 Robert L. Rabin, *Tobacco Control Strategies: Past Efficacy and Future Promise*, 41 Loy. L.A. L. Rev. 1721 (2008). My perspective then, and in this Article as well, is limited primarily to the United States. The global public health consequences associated with smoking are extraordinarily serious. While the initiatives discussed here should have salience elsewhere, context is critical in assessing the problem and proposed resolutions, and consequently is beyond the scope of this Article. For information on global tobacco mortality and coverage of anti-tobacco legislation, see World Health Org., WHO Report on the Global Tobacco Epidemic, 2011 (2011), *available at* http://whqlibdoc.who.int/publications/2011/9789240687813_eng.pdf (reporting six million yearly deaths and rising smoking rates in developing countries). For survey data and analysis of smoking in sixteen countries, see Gary A. Giovino et al., *Tobacco Use in 3 Billion Individuals from 16 Countries: An Analysis of Nationally Representative Cross-Sectional Household Surveys*, 380 Lancet 668 (2012) (survey data showed high smoking rates among men, early smoking initiation among women, and low quit ratios among smokers). For analysis of global tobacco sales data, see Simon Bowers, *Global Profits for Tobacco Trade Total $35bn As Smoking Deaths Top 6 Million*, Guardian, Mar. 21, 2012, http://www.guardian.co.uk/business/2012/mar/22/tobacco-profits-deaths-6-million.

2 Office of the Surgeon Gen., Smoking and Health: Report of the Advisory Committee to the Surgeon General of the Public Health Service (1964).

Act of 2009 (FSPTCA);[3] the resort by the industry to litigation in a new guise — particularly reliant on the First Amendment — as an offensive weapon targeting regulatory controls, in contrast to traditional common law defensive efforts in the tort litigation; and the publication of the 2012 Surgeon General's Report on youth smoking,[4] which makes the case for top-priority attention to underage smoking behavior. On the latter score, New York City has continued to innovate in devising new efforts — not always successful in court — to reduce teenage smoking. These and related measures point to new pathways for breaking through a perceived recent loss of momentum in achieving further reductions in tobacco-related disease — new pathways, I would emphasize, without abandoning what has worked in the recent past.

My Article proceeds as follows. Part I begins with a discussion of the most recent data on the demographics of smoking behavior. Then, Part II turns to an update on past successes; in particular, raising the question of whether these strategies show continuing promise beyond holding the line on current successes. This, in turn, leads to discussion of what might be regarded as a new generation of tactics and counter-tactics, in part triggered by the FSPTCA, and in part animated by enhanced industry promotional and price-discounting strategies at point of sale. I pull together these multiple fronts in Part III, focused on youth smoking, in which I assess the promise of present efforts to reduce the harms associated with tobacco. Part IV offers some brief thoughts from a broader public-health perspective, discussing the framework of tobacco control initiatives from the vantage point of the obesity problem. Part V concludes.

I. The Demographics of Smoking Behavior

The stark reality of the magnitude of the public health concern associated with cigarette smoking is brought home by the current estimate of 443,000 premature deaths in the United States — a number far exceeding the annual mortality from any other source of preventable death.[5] Looking forward, the figure does require qualification. Cigarette smoking — in its origins, very

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3 Family Smoking Prevention and Tobacco Control Act (FSPTCA), Pub. L. No. 111-31, 123 Stat. 1776, 1781 (2009) (codified as amended in scattered sections of 5 U.S.C., 15 U.S.C., and 21 U.S.C.).

4 Office of the Surgeon Gen., Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General (2012).

5 Ctrs. for Disease Control & Prevention, *Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses — United States, 2000-2004*, 57 Morbidity & Mortality Wkly. Rep. 1226 (2008).

much a twentieth century phenomenon — was ubiquitous as late as 1965, when forty-two percent of the adult population counted as regular tobacco users.[6] That figure has dropped dramatically: by 2010, slightly less than twenty percent of the adult population continued to smoke.[7] And taking account of the long latency of the principal diseases associated with tobacco use, one can project a gradually falling death toll over the coming years, even if the trend-line in smoking reduction remains flat.

But the latter prospect is precisely the basis for continuing serious concern: the trend-line in smoking prevalence has in fact been relatively flat since 1992 at a figure — one-fifth of the adult population — that is obviously a considerable proportion of the adult population. And perhaps of greatest concern, the estimates of youth smoking appear to show similar characteristics. Survey data reported in the 2012 Surgeon General's Report estimates that about nineteen percent of high school seniors engaged in smoking on a regular basis.[8] The urgency of this concern is underscored by correlative reports that eighty-eight percent of adult smokers began using tobacco before the age of eighteen.[9]

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6 Ctrs. for Disease Control & Prevention, *Quitting Smoking Among Adults — United States 2001-2010*, 60 Morbidity & Mortality Wkly. Rep. 1513 (2011).

7 *Id.*; *see also* Ctrs. for Disease Control & Prevention, Vital Signs: Adult Smoking in the US 3 (2011) (adult population data, by race, indicates current smoking rates of 31.4% among American Indian or Alaskan natives, 25.9% of individuals reporting multiple racial identities, 21% identifying as white, 20.6% as black, 12.5% as Hispanic, and 9.3% as Asian). Despite the overall decrease in smoking among adults in the United States, the prevalence of cigarette smoking among young adults at or below the poverty line began to increase in 2007, while rates for young adults above the poverty line continued to decrease. Office of the Surgeon Gen., *supra* note 4, at 142. Most studies define "adult smokers" as those who smoke at least once a day. Office of the Surgeon Gen., *supra* note 4, at 70.

8 Office of the Surgeon Gen., *supra* note 4, at 135. Studies typically define a "youth smoker" as one who smokes at least once a month or week. *Id.* at 70. Recent data from the National Institute on Drug Abuse at the University of Michigan is more encouraging (although it included younger teenagers in its survey, as well), reporting just under eleven percent usage. *See* Jennifer Dooren, *Teen Smoking Keeps Falling*, Wall St. J., Dec. 30, 2012, at A3.

9 Office of the Surgeon Gen., *supra* note 4, at 134. The FSPTCA made the sale of tobacco products to those under eighteen illegal, which matches the minimum age in all but three states (Alabama, Alaska, Utah) where sales of tobacco products are banned to those under nineteen. *An Outline for Model Legislation*, Preventing Tobacco Addiction Found., http://www.tobacco21.org/action/ (last visited Apr. 30, 2013). New York City is currently considering a proposal that

Summing up, then, it is a genuine cause of public health concern that the premature deaths from smoking remain in excess of 400,000 per year; that adult and youth smoking is still engaged in by a prominent segment of the population; and that reduction in smoking prevalence seems to have tailed off considerably. Do the successes of the past suggest staying the course, or do they call for new directions in public-health strategies for the future?

II. Past as Prelude to the Future?

I begin with discussion of a strategic move that has *not* been taken in the past: a total ban on tobacco use. In view of the statistical evidence that smoking rates appear to have stabilized, do the continued devastating health consequences associated with long-term smoking warrant making tobacco use illegal, not just for minors but as an adult activity, as well?

Interestingly, one hears less resort to the philosophical argument for continued deference to smokers' rights — that is, respecting individual autonomy — than was true in the early days of the antismoking movement.[10] This is probably the case for a variety of reasons. First, and perhaps foremost, as the evidence has become robust that serious health consequences are associated with secondhand smoke exposure, the externalities attendant upon respecting smokers' rights have undermined the "victimless crime" position.[11] Or to put it another way, whose individual rights is the government to protect? Second, the individual autonomy position has been directly challenged by the emergence of a body of scientific evidence indicating the addictive character of smoking (and in particular, the properties of nicotine).[12] Correlatively, there

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would raise the minimum age to twenty-one. *See* Nicholas Bakalar, *Debating Age Limits on Tobacco*, N.Y. Times, Apr. 30, 2013, at D5.

10 *See, e.g.*, Robert E. Goodin, No Smoking: The Ethical Issues (1989). Assuming I am correct, it does not follow, of course, as a normative proposition that the autonomy argument has lost force. As many have pointed out, there are any number of high-risk leisure activities that individuals are allowed to pursue even if they may be risking serious injury or death. None raise public health or safety concerns comparable to smoking. But that elides the question from a strong libertarian perspective, which would reject the assumption that a welfare norm (public health) should override an individual rights norm.

11 U.S. Envtl. Prot. Agency, Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders (1992); text accompanying *infra* notes 25-30.

12 U.S. Dep't of Health & Human Serv., Nat'l Inst. on Drug Abuse, Research Report Series: Tobacco Addiction Bethesda (2012); Office of the Surgeon

is substantial survey data indicating smokers' regrets over their inability to quit.[13] And finally, as youth smoking has emerged as the central focus of public health concern, the individual autonomy position has lost its foothold to some extent in the face of a consensual regard for protecting the young from a major behavioral consequence of their immaturity: the tendency to radically discount long-term risks.[14]

In hindsight, the pragmatic arguments for refraining from an outright ban on tobacco use have probably always outweighed the philosophical position in the arena of public policy.[15] The specter of Prohibition Era criminal activity and general disrespect for the law has continuing resonance. And this in the context of an activity engaged in by fully one-fifth of the adult population. Moreover, this is not merely a historical datum: there is a flourishing market in illegal transport of cigarettes, much of it related to tax avoidance in high-excise tax states, but more broadly related as well to cross-boundary smuggling from Indian reservations and foreign countries.[16] Obviously, the concern is

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Gen., The Health Consequences of Smoking: Nicotine Addiction (1988).

13 Geoffrey T. Fong et al., *The Near-Universal Experience of Regret Among Smokers in Four Countries: Findings from the International Tobacco Control Policy Evaluation Survey*, 6 Nicotine & Tobacco Res. (Supp.) 3 (2004).

14 Youth smoking is discussed in *infra* Part III. In an interesting turn, resurrecting the individual autonomy argument, New York City is considering a proposal to raise the minimum age of sale of tobacco products to twenty-one — triggering criticism that beyond a more conventional age limit (eighteen in most states, as indicated above), a governmental proscription treads on individual rights of adults. *See* Anemona Hartocollis, *City Plan Sets 21 as Legal Age to Buy Tobacco*, N.Y. Times, Apr. 23, 2013, at A1.

15 Indeed, the philosophical position has probably realized its greatest influence — perversely from the victims' perspective — in the tobacco tort litigation, in which the assumed risk defense has been prominent from the outset and continues to wield considerable force. *See* text accompanying *infra* notes 64-68.

16 New York, for example, has made attacking trafficking a major priority in view of clandestine shipments from Virginia (a low-tax state) and from Indian reservations. In the latter case, the approach has been to require that the excise tax be paid prior to shipment, except for amounts designated for personal use on the reservation. Telephone interview with Kevin Schroth, Senior Legal Counsel, Bureau of Chronic Disease Prevention & Tobacco Control, N.Y.C. Dep't of Health & Mental Hygiene (Apr. 1, 2013). For a description of the rule, see *Amendments to the Tax Law Related to Sales of Cigarettes on Indian Reservations Beginning September 1, 2010*, Office of Tax Policy Analysis Taxpayer Guidance Div., N.Y. St. Dep't of Tax'n & Fin. (July 29, 2010), http://www.tax.ny.gov/pdf/memos/multitax/m10_6m_8s.pdf. On the international dimension of the problem, see World Health Org., The Tobacco Atlas 54 (2002); and Marina Walker

that this illicit activity would be greatly exacerbated by an outright ban on tobacco use. There is also a product substitution issue, which I will discuss further in the next Part.[17]

Finally, there is yet another pragmatic argument for avoiding a ban; namely, that an outcome approximating a *de facto* ban may be achievable without formal resort to a *de jure* ban. Clearly, at some point a near-confiscatory excise tax would be tantamount to a ban on use. New York City may, in fact, be approaching this point with regard to the youth market — a point that I will discuss further below.[18] And despite the contrary evidence that smoking rates in most states have remained relatively stable in recent years notwithstanding continued excise tax increases, many antismoking health policy advocates hold out the hope that further substantial reductions in smoking can be achieved through multipronged control initiatives.[19] I next examine these initiatives, past and present.

A. Taxation

Econometric studies of the price-sensitivity of smokers have been a staple of public policy analysis of tobacco control initiatives. While the results have varied, there is a long-standing consensus that the demand for cigarettes is relatively price-sensitive for adults and even more so for youths; leading authorities have estimated that a ten percent increase in price drives down adult

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Guevara, *The World's Most Widely Smuggled Substance*, Int'l Consortium of Investigative Journalists (Oct. 20, 2008, 12:00 AM), http://www.icij.org/project/tobacco-underground/worlds-most-widely-smuggled-legal-substance. For tables comparing state taxes and smuggling, see Joseph Henchman & Scott Drenkard, *Cigarette Taxes and Cigarette Smuggling by State*, Tax Found. (Jan. 10, 2013), http://taxfoundation.org/article/cigarette-taxes-and-cigarette-smuggling-state.

17 *See infra* note 95. Comprehensive discussion of this important topic is beyond the scope of this Article. *See generally* Frank J. Chaloupka et al., *Tobacco Taxes as a Tobacco Control Strategy*, 21 Tobacco Control 172 (2012) (arguing that studies generally show that reductions in the use of a tobacco product due to an increase in its price will be partially offset by the increased use of other tobacco products if those prices are not also raised); Michelle Da Pra & Carlos Arnade, Tobacco Product Demand, Cigarette Taxes and Market Substitution, Selected Paper Presented at the Agricultural & Applied Econ. Ass'n & Am. Council on Consumer Interests Joint Meeting (July 2009), *available at* http://ageconsearch.umn.edu/bitstream/49210/2/AAEA_final_draft_michelle.pdf.

18 *See infra* note 97.

19 *See generally* Inst. of Med., Ending the Tobacco Problem: A Blueprint for the Nation (2007) [hereinafter IOM Report].

consumption by three to five percent and decreases the prevalence of smoking among youths by fourteen percent.[20] But there is a baseline question whether this strategy has now run its course. Recently, California citizens, who have been among the most enthusiastic supporters of tobacco reduction policies, rejected an initiative that would have led to a further excise tax increase of one dollar per pack of cigarettes.[21] Similarly, New York City health advocates, whose commitment to further reducing tobacco use has not flagged, have no current plans to introduce further city tax increases.[22]

On this score, however, it should be noted that there is an exceptionally wide span of excise tax rates among the states. In 2011, state excise taxes ranged from $0.17 per pack in Missouri to $4.35 per pack in New York (not including the federal excise tax).[23] It may well be that some of the low-incidence

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20 F. Chaloupka & K. Warner, *The Economics of Smoking*, *in* Handbook of Health Economics 1539 (A.J. Cuyler & J.P. Newhouse eds., 2000); Alexander Ding, *Youths Are More Sensitive to Price Changes in Cigarettes than Adults*, 76 Yale J. Bio. & Med. 76, 115 (2003). These studies may require some degree of qualification for having been done prior to the present-day prevalence amongst what might be taken to be "hard-core" smokers (at least among adults). On this score, see Matthew C. Farrelly, Terry F. Pechacek, Kristin Y. Thomas & David Nelson, *The Impact of Tobacco Control Programs on Adult Smoking*, 98 Am. J. Pub. Health 304 (2008) (finding that cigarette prices had a stronger effect on smoking prevalence among eighteen to twenty-four year-olds than adults twenty-five and older); *see also* Peter Franks et al., *Cigarette Prices, Smoking, and the Poor: Implications of Recent Trends*, 97 Am. J. Pub. Health 1873 (2007) (finding a dramatic drop in price sensitivity among adults following the Master Settlement Agreement, which may reflect the fact that continuing smokers are more addicted and thus less sensitive to price).

21 Seth Cline, *California Cigarette Tax Proposal Sunk by Big Tobacco*, U.S. News, June 8, 2012, http://www.usnews.com/news/articles/2012/06/08/california-cigarette-tax-proposal-sunk-by-big-tobacco.

22 See text accompanying *infra* notes 96-105 for current New York City strategy initiatives.

23 *See* Orzechowski & Walker, The Tax Burden on Tobacco: Historical Compilation (2011) (cited in *State Cigarette Excise Tax Rates & Ratings*, Campaign for Tobacco Free Kids (Dec. 3, 2013), http://www.tobaccofreekids.org/research/factsheets/pdf/0097.pdf (ranking Virginia ($0.30), Louisiana ($0.36), and Georgia ($0.37) as the states with the lowest rates after Missouri; and Rhode Island ($3.50), Connecticut ($3.40), and Hawaii ($3.20) as those with the highest rates after New York)). The federal excise tax stands at $1.01, a substantial increase from not long ago when there was considerable resistance to using taxation as a control initiative at the federal level. On average, federal and state taxes accounted for 44.1% of the retail price of cigarettes. *Id.* at iv. In his current budget proposal,

states have a greater receptivity to excise tax increases at this point than the high-incidence states.

It should also be noted that the regressive character of the excise tax may have especially serious secondary public-health consequences for lower socioeconomic class smokers in high-tax communities. A recent study finds that lower-income smokers, who tend to smoke at more than twice the rate of higher-income smokers in New York State, spend twenty-four percent of their household income on smoking — a significant increase over the past decade.[24]

An overall assessment, in my view, would be that the excise tax will continue to serve as a major constraint on smoking prevalence, especially in high-tax states. But as a lever to further reduction of smoking rates, it will probably play a secondary role at this point.

B. Public Place Restrictions

Restrictions on smoking in public places took off dramatically beginning in the mid-1980s as studies were published indicating the health risks associated with secondhand smoke exposure.[25] By 2006, eighteen states and nearly 350 municipalities had banned smoking in restaurants and forty-four states had banned workplace smoking.[26] The steady increase in restrictions continues. In early 2013, data indicate that twenty-five states and approximately 561 municipalities have enacted such bans.[27]

The most striking move in recent years has been the enactment of bans beyond enclosed places of public entertainment — bans in public parks, sports

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President Obama has proposed a further ninety-four percent increase in the federal per pack excise tax. *See* John Kell, *Where There Is Smoke, There's also Profit*, Wall St. J., Apr. 22, 2013, at B2. For discussion of recent profitability reports, see Michael Felberbaum, *Reynolds American 1Q profit jumps 88 pct, Associated Press: The Big Story*, Apr. 23, 2013, http://bigstory.ap.org/article/reynolds-american-1q-profit-jumps-88-pct.

24 *See* Farrelly et al., *The Consequences of High Cigarette Taxes for Low-Income Smokers*, Plos One, (Sept. 12, 2012), http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0043838.

25 Office of the Surgeon Gen., The Health Consequences of Involuntary Smoking (1986); *see also* U.S. Envt'l Prot. Agency, Respiratory Health Effects of Passive Smoking (1993). For more detail on government studies, see Rabin, *supra* note 1, at 1725 n.19.

26 IOM Report, *supra* note 19, at 191, 245.

27 *U.S. 100% Smokefree Laws in Non-Hospitality Workplaces and Restaurants and Bars Enacted as of January 2, 2014*, Am. Nonsmokers' Rts. Found. (Jan. 2, 2014), http://www.no-smoke.org/pdf/WRBLawsMap.pdf.

arenas, and areas abutting public buildings. New York City, maintaining its highly proactive antismoking position, banned smoking in public parks, plazas, and beaches in 2011, and in entry areas near hospitals two years earlier.[28] In California, smoking is completely prohibited at football stadiums and all major league baseball parks, except for the Angels' stadium in Anaheim, where people can smoke in designated areas.[29] Many municipalities have banned smoking in a wide array of outdoor areas: beaches, public transit waiting areas, outdoor dining and bar patios, and parks.[30] A number of communities now prohibit smoking in condos and other multiunit dwellings, and smoke-free hotels and motels have become commonplace across the nation.

What these recent initiatives demonstrate most clearly is a dramatic change in cultural attitudes towards smoking, rather than new findings on the health consequences of secondhand smoke exposure. Not even the most avid beachgoers or sports fans spend a sufficient amount of time engaged in these leisure pursuits to document health risks from inhaling secondhand smoke at these sites, entirely apart from the lesser risks entailed by *outdoor* exposure. The contrast is sharp from workplace exposure in restaurants and bars, let alone nonsmoking family member exposure in private dwellings (where ironically, restrictions are largely nonexistent despite the strongest evidence of respiratory health effects).

Has the forward regulatory momentum peaked in this domain, as in the case of the excise tax? It is difficult to say. Once again, there is great variation in regulation across the nation. And to a significant extent, this has been a grassroots movement: local communities have taken the lead — where no

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28 N.Y. City Admin. Code §§ 17-502, 17-503, 17-507, 17-508 (as amended by City of New York Local Law 11 for the Year 2011 and City of New York Local Law 50 for the Year 2009).

29 *Smoking Policies at Major League Baseball Stadiums*, Am. Nonsmokers' Rts. Found. (Apr. 5, 2013), http://www.no-smoke.org/pdf/majorleaguebaseballstadiumpoliices.pdf; *Smoking Policies at NFL Stadiums*, Am. Nonsmokers' Rts. Found. (July 25, 2012), http://www.no-smoke.org/pdf/smokingpoliciesNFLstadiums.pdf.

30 *Municipalities with Smokefree Beach Laws Enacted as of Jan. 2, 2014*, Am. Nonsmokers' Rts. Found. (Jan. 2, 2014), http://www.no-smoke.org/pdf/SmokefreeBeaches.pdf; *Municipalities with Outdoor Public Transit Waiting Area Laws Enacted as of January 2, 2014*, Am. Nonsmokers' Rts. Found. (Jan. 2, 2014), http://www.no-smoke.org/pdf/SmokefreeTransitStops.pdf; *Municipalities with Smokefree Outdoor Dining and Bar Patio Laws Enacted as of Jan. 2, 2014*, Am. Nonsmokers' Rts. Found. (Jan. 2, 2014), http://www.no-smoke.org/pdf/SmokefreeOutdoorDining.pdf; *Municipalities with Smokefree Park Laws Enacted as of Jan. 2, 2014*, Am. Nonsmokers' Rts. Found. (Jan. 2, 2014), http://www.no-smoke.org/pdf/SmokefreeParks.pdf.

state preemption exists — in adopting measures at the local level. So it may well be that smoke-free initiatives will continue to expand in number, as well as in breadth of coverage (that is, outdoor areas) in particularly or newly proactive communities.

Arguably, the most consequential aspect of the smoke-free movement has been its impact on smokers themselves, rather than the immediately-intended beneficiaries — the nonsmoking public. While it is difficult to document with any precision, the combined effect of stigma from visibly huddling in zones of still-permitted smoking, and hassle from smoking restricted drastically in time and place, can be taken to have contributed significantly to reduction in smoking prevalence. Here, too, even if the movement has nearly run its course, there is no prospect of turning back — and the consequence is to substantially reduce the satisfactions derived from smoking.

C. Health-Related Information

Published in 1964, The Surgeon General's Report on Smoking and Health was a landmark in raising public awareness of the health risks of smoking.[31] Its central findings on the relationship between smoking and lung cancer — based on a systematic review of the scientific evidence, rather than original research — animated a sharp decline in smoking, and a strong reaction by the tobacco industry in expanded marketing of filter-tip cigarettes and vigorous promotion of image advertising (the Marlboro Man, created slightly earlier, being perhaps the leading example).[32] In fact, however, a private-sector initiative — a series of articles in the widely-read Reader's Digest — had chronicled the initial round of evidence of cancer-related risks from smoking a decade earlier.[33]

This first wave of health-related information was particularly targeted at the smoking public, defined broadly to include prospective as well as current smokers.[34] Two decades later, a second wave of health-related information was

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31 Office of the Surgeon Gen., *supra* note 2. There have been annual reports on various tobacco topics in the ensuing years. As mentioned, the 1986 report on secondhand smoke exposure, Office of the Surgeon Gen., *supra* note 25, was particularly influential. The 2012 report on youth tobacco use is referred to throughout this Article.

32 *See* Allan M. Brandt, The Cigarette Century 261-64 (2007).

33 The first of these articles was Roy Norr, *Cancer by the Carton*, Reader's Digest, Dec. 1952, at 7.

34 Note, too, the importance of nongovernmental reporting of health information in newspapers and magazines throughout the ensuing decades. *See, e.g.*, Stanton A. Glantz, The Cigarette Papers (1996) (discussing the wide media coverage

channeled to a wider audience: the general public (particularly nonsmokers). As mentioned above, this information was, in the first instance, focused on the risks of secondhand smoke exposure.[35] But within a decade, the tobacco tort litigation — which had gestated from decades of unsuccessful case-by-case efforts into aggregate multistate and private class action litigation — contributed to unearthing a flood of internal industry documents that revealed systematic efforts on the part of the industry to mislead (and deceive) the public about the risks of tobacco use.[36] Now, the industry's image was notably transformed in the political arena — where tax increases, public place restrictions, and advertising limitations became fair game.

More recently, a third wave emerged, redirecting the health-risk information back to present and prospective smokers, with a special emphasis on the youth market. These media ads in fact had appeared in the second wave; so-called counter-advertising had its origins in the 1980s, promoted by government at the state and local level.[37]

But a new set of initiatives was introduced by the enactment in 2009 of the Family Smoking Prevention and Tobacco Control Act, empowering the Food and Drug Administration (FDA) to exercise jurisdiction over the tobacco industry.[38] The act anticipated action by the FDA to devise stronger cigarette package health-risk warnings than were in effect under the 1984 federal warning label legislation, and to bolster the stronger warnings with graphic imagery on the cigarette package.[39]

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of the Surgeon General's 1964 report, including Life Magazine and the New York Times).

35 *See* Office of the Surgeon Gen., *supra* note 25.

36 *See* Brandt, *supra* note 32, at 357-91.

37 In fact, even earlier a federal court ruling in 1968, Banzhaf v. FCC, 405 F.2d 1082 (D.C. Cir. 1968), interpreted the Federal Communications Commission's (FCC's) "fairness doctrine" to require industry responsibility for health-risk warnings along with media cigarette advertising. These public service ads ran for three years before Congress enacted legislation banning tobacco advertising on the broadcast media. *See* Brandt, *supra* note 32, at 267-72.

38 Family Smoking Prevention and Tobacco Control Act (FSPTCA), Pub. L. No. 111-31, 123 Stat. 1776 (2009). An initial effort by the FDA to assert jurisdiction over the industry, without express enabling legislation, was struck down by the U.S. Supreme Court in *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120 (2000).

39 Title II of the FSPTCA amended the Federal Cigarette Labeling and Advertising Act, Pub. L. 98-474 (codified at 15 U.S.C. § 1333 (1984)), which required cigarette advertisements and packages to contain in rotation one of four warnings: "Smoking Causes Lung Cancer, Heart Disease, Emphysema, and May Complicate

The FDA implemented this mandate by adopting nine graphic images — one for each new health warning — portraying vividly the ravages of smoking-related disease, along with a corresponding requirement that a help-quit phone line be posted.[40] The industry was quick to react, challenging the requirements of graphic images and a help phone line on First Amendment grounds. In *R.J. Reynolds Tobacco Co. v. FDA*,[41] the D.C. Circuit Court of Appeals dealt a serious blow to the FDA's cornerstone informational initiative by striking down the regulations. The court held (2-1) that the agency failed to overcome the limitations on the regulation of commercial advertising established by the Supreme Court in *Central Hudson Gas & Electric Co. v. Public Service Commission*[42] — limitations that, according to the majority, required substantial evidence that the graphic warning labels would contribute to a decline in smoking prevalence.[43] Rather than seek Supreme Court review,

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Pregnancy," "Quitting Smoking Now Greatly Reduces Serious Risks to Your Health," "Smoking By Pregnant Women May Result in Fetal Injury, Premature Birth, And Low Birth Weight," or "Cigarette Smoke Contains Carbon Monoxide." By contrast, section 201 of the FSPTCA lists nine new textual warnings, including "Smoking can kill you," "Cigarettes are addictive," and "Cigarettes cause cancer." It also increased the size of the warnings relative to advertising and packaging space and mandates that graphic label images supplement the textual warnings. *See* FSPTCA, 15 U.S.C. §§ 201(a)(1), (a)(2), (c), (d). The Act also contains provisions requiring the industry to reveal ingredients of tobacco products and to refrain from product advertisements with implicitly misleading positive health messages, including "light" or "low tar" designations. *See* FSPTCA, 21 U.S.C. § 387 ("Modified Risk Products").

40 Food and Drug Administration Required Warnings for Cigarette Packages and Advertisements, 76 Fed. Reg. 36,628, 36,631 (2011) (final rule).

41 R.J. Reynolds Tobacco Co. v. FDA, 696 F.3d 1205 (D.C. Cir. 2012).

42 Cent. Hudson Gas & Elec. v. Pub. Serv. Comm'n, 447 U.S. 557 (1980).

43 Although neither the industry nor the court questioned the longstanding health warnings on cigarette packages, on first impression the "intermediate scrutiny" standard of a data-based linkage between warning message and reduced smoking prevalence articulated by the *R.J. Reynolds* majority opinion sets the bar higher than *any* requirement of package health warnings could satisfy. Almost certainly, however, the 1984 (and earlier) warning labels survive under *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626 (1985), upholding compelled speech that satisfies "rational basis" review where factual information to avoid misleading commercial speech is involved. In essence, rejection of the FDA's graphic images turns on a dubious distinction between "factual" and "emotional" content — portraying the graphic warnings as nonfactual disclosure requirements that offend First Amendment commercial speech protection.

the FDA retreated to the position of trying to redraft watered-down graphic images that would pass judicial muster.[44]

New York City's counterpart effort to require industry posting of graphic warning images at point-of-sale suffered a similar fate, on different grounds, in *23-34 94th St. Grocery Corp. v. N.Y. City Bd. of Health*.[45] In 2009, the New York City Board of Health had adopted a resolution providing that signs be located either next to the cash register or next to the tobacco product display in retail establishments, containing one of three vivid, graphic health messages (and a help-quit phone line).[46] Retailers and tobacco manufacturers argued for invalidity both on First Amendment and preemption grounds — the latter based on the federal cigarette warning label act provision that no advertising or promotion restrictions beyond those in the federal act be adopted.[47]

The court relied on the federal preemption clause to invalidate the city's resolution, holding that a requirement that the retailer place graphic warning signage near either the cash register or the product display constituted a preempted restriction on promotion of the product.[48] In doing so, the court rejected the city's argument that the resolution was a restriction on sale, rather than on promotion, along with its effort to carve out an exception for such restrictions if they targeted only retailers and not manufacturers. The court

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44 Contrary to *R.J. Reynolds*, the Sixth Circuit Court of Appeals upheld the constitutionality of the statutory requirement of graphic warning labels in *Discount Tobacco City & Lottery v. U.S.*, 674 F.3d 509 (6th Cir. 2012), *cert. denied sub nom* American Snuff Co. v. U.S., No. 12-521, WL 1704718 (Apr. 22, 2013). *See* Rent Kendall & Jennifer Corbett Dooren, *Tobacco Industry's Challenge to Law Requiring Graphic Labels Is Rejected*, Wall St. J., Apr. 23, 2013, at A5. But the Sixth Circuit opinion was based on review of the FSPTCA provision itself, granting authority to develop graphic images, rather than final images chosen by the FDA. Nonetheless, as the FDA redrafts its graphic warning labels, this holding provides some prospect that graphic images are not a dead letter. *Discount Tobacco* did hold, however, that the Act's blanket requirement of exclusively black-and-white, text-only advertising ("tombstone advertising") was an unconstitutional restriction under the First Amendment.

45 23-34 94th St. Grocery Corp. v. N.Y. City Bd. of Health, 685 F.3d 174 (2d Cir. 2012).

46 N.Y. City Health Code, § 181.19 (2009).

47 Comprehensive Smoking Education Act of 1984, 15 U.S.C. § 1334(b) (1984). The federal cigarette warning label preemption provision was held to preempt state tort law negligent failure-to-warn claims in the leading case of *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504 (1992).

48 The court did not reach the First Amendment issue.

instead looked at the resolution's impact on consumers to determine whether it affected the content of advertising messages.

Taken together, the two cases, if they stand up, appear to place an upper limit — the warning language in the federal cigarette warning legislation — on the informational content disclosures that can be imposed on the industry.[49]

It is critical to recognize what these cases leave untouched, even assuming they have laid to rest an efficacious requirement of graphic warning labels on the cigarette package or at the retail counter. In no way do the opinions cast doubt on the government's *own* capacity to generate health-risk warnings.[50] In that regard, New York City, for example, continues a decade-long practice of investing heavily in ads focusing on "shocking" images, showing smoking-related suffering and family-related distress over the ravages of tobacco use.[51] To a varying degree, this mirrors a similar resort to public health-risk warning campaigns elsewhere, as well.[52] However, as funding from the Master Settlement Agreement with the tobacco industry, discussed below, has been diverted to other programs, the nationwide resort to this strategy has waned.[53]

D. Tort Litigation

In quiet fashion, the first modern assault on the citadel of tobacco occurred in the mid-1950s, almost immediately after the health scare generated by the Reader's Digest series on smoking and cancer.[54] But for forty years, in a striking succession of failed efforts, tort litigation yielded nothing beyond the imposition of substantial attorneys' fees on the industry in successfully

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49 *But see Discount Tobacco*, 674 F.3d.

50 Indeed, the *23-34 94th St.* opinion is explicit that "the City may seek to tilt the balance further [in educating consumers] . . . by launching its *own* anti-smoking campaign." *23-34 94th St.*, 685 F.3d, at 185.

51 Telephone interview with Kevin Schroth, *supra* note 16. Based on experience, New York City determined that ads focusing on getting healthy were not effective in altering smoking behavior.

52 *See* Trust for America's Health, Investing in America's Health: A State-by-State Look at Public Health Funding and Key Health Facts (2012), *available at* http://healthyamericans.org/assets/files/TFAH2012InvstgAmrcsHlthTobAdvSigns.pdf; *Tobacco in the Retail Environment: Fact Sheet*, Cal. Dep't of Pub. Health, http://www.cdph.ca.gov/programs/tobacco/Documents/Tobacco%20Retail%20Environment%20Fact%20Sheet_Easy%20Print.pdf (last visited May 15, 2012).

53 *See generally* IOM Report, *supra* note 19, at 224-31.

54 *See supra* note 33, and accompanying text. For discussion of the first two waves of tort litigation, from the mid-1950s to the early 1990s, see Robert L. Rabin, *A Sociolegal History of the Tobacco Tort Litigation*, 44 Stan. L. Rev. 853 (1992).

defending the cases. Then, in the mid-1990s, came the revelations in industry documents of a pattern of deceptive advertising and efforts to suppress health information research, encouraging a consortium of plaintiffs' attorneys to launch class action litigation, contemporaneous with multistate attorneys general efforts to secure reimbursement for public health expenditures for treatment of smoking-related disease.[55] Although the class action tort litigation was successfully rebuffed — with one notable exception to be discussed below — the multistate reimbursement effort eventually led to the Master Settlement Agreement (MSA): a $206,000,000,000 settlement with the industry in 1998, a setback softened by the extended payout period (twenty years) and the foreclosure of one major source of litigation uncertainty.[56]

Tort litigation, obviously, is not an affirmative government strategy, in the sense of those discussed earlier. Nonetheless, tort damage awards are functionally a control device to the extent that they contribute to price increases that potentially suppress demand. The MSA appears to have had a short-term effect along these lines.[57] And continuing substantial industry attorneys' fees — even if successful in warding off damage awards — similarly contribute to the industry's cost of doing business. But there is substantial reason to conclude that in the overall scheme of tobacco control, the tort litigation has played a minor role and probably will make a still-more diminished contribution in the future.

I reach this conclusion for a number of reasons. But before elaborating on the point, the singular pathway of class action litigation in Florida, initiated in *R.J. Reynolds, Co. v. Engle*,[58] warrants attention. Like the statewide class actions elsewhere, following on the unsuccessful nationwide class action in *Castano v. American Tobacco Co.*,[59] the Florida Supreme Court eventually decertified the class on the grounds that the individual plaintiffs were too diverse — in terms of diseases claimed, knowledge of risk, and circumstances of exposure — to satisfy the commonality of interest required for class aggregation.[60]

The distinctive aspect of the Florida Supreme Court decertification was that it constituted a reversal of course: Florida appellate courts had earlier upheld

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55 *See* Brandt, *supra* note 32, at 401-30; Robert N. Proctor, Golden Holocaust 257-481 (2011).

56 *See* Brandt, *supra* note 32, at 431-34. Four states had settled earlier, bringing the total figure to $246,000,000,000.

57 *Id.* at 434-35.

58 R.J. Reynolds, Co. v. Engle, 672 So. 2d 39 (Fla. 3d Dist. Ct. App. 1996).

59 Castano v. Am. Tobacco Co., 84 F.3d 734 (5th Cir. 1996). On the *Castano* progeny state class action litigation generally, see Susan E. Kearns, *Decertification of Statewide Tobacco Class Actions*, 74 N.Y.U. L. Rev. 1336 (1999).

60 Engle v. Liggett Grp., Inc., 945 So. 2d 1246 (Fla. 2006).

a phased class certification, leading the district court on initial remand to issue findings on general causation and misleading conduct by the industry, along with awards in favor of representative plaintiffs. As a consequence, when the Florida Supreme Court eventually had second thoughts and overturned the class certification (and the representative case awards), it held that individual tobacco plaintiffs who pursued tort claims could treat the earlier determinations of generic causation and industry misconduct as res judicata and limit their burden to establishing the comparative case of tobacco defendant responsibility.[61]

This aftermath is now in full progress. The Public Health Advocacy Institute, which tracks the so-called *Engle* progeny cases, reported that as of July 2013, ninety-seven of the Florida cases, excluding mistrials, had been decided — sixty-seven of which resulted in plaintiff's awards.[62] And annual report data from the largest of the three U.S. tobacco companies, Altria (Philip Morris), makes reference to about 1500 *Engle* progeny cases.[63] But strikingly, only twenty of these cases were active (the remainder having been stayed); correspondingly, thirty-seven had been decided, nineteen of which resulted in plaintiff's verdicts and eighteen in defense verdicts.[64] More generally, apart from *Engle* progeny cases, Altria reported nationwide only seventy-one individual tort cases pending as of April 2013, down from seventy-nine a year earlier, and eighty-nine in 2011; and correspondingly, excluding the progeny cases, since 1999, fifty-two verdicts nationwide of which thirty-five were in favor of defendant.[65]

What can be said, then, about the profile of tobacco tort litigation? The Florida litigation itself suggests a cautionary note. Note that the *Engle* progeny litigation began four years ago, and despite the 1500 pending cases, only thirty-seven have been decided at this point, with a success rate, not counting mistrials, of roughly fifty percent for the plaintiffs and a modest number of actively pending cases. As this win-percentage suggests, the cases are neither

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61 *Id.* This holding was reaffirmed when challenged on due process grounds in *Philip Morris, USA, Inc. v. Douglas*, 110 So. 3d 419 (Fla. 2013).

62 E-mail from Ed Sweda, Senior Attorney, Pub. Health Advocacy Inst., to author (June 26, 2013) (on file with author).

63 *See U.S. Securities & Exchange Comm'n, Form 10-Q, Quarterly Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 for the Quarterly Period Ended March 31, 2013*, Altria Grp., Inc., http://services.corporate-ir.net/SEC.Enhanced/SecCapsule.aspx?c=80855&fid=8770379 (last visited Mar. 29, 2014).

64 *Id.*

65 *Id.* This total includes a small number of "Lites/Ultralites" and healthcare recovery cost cases.

slam-dunk — individual responsibility of the plaintiff remains a potent defense — nor are they creating immediate floodgates concerns for the industry.

More salient is the nationwide perspective. Over the two decades since the revelations of industry wrongdoing created new prospects for establishing legal responsibility in individual cases, only sporadic success has been realized in these cases.[66] And the future does not bode especially well. From the beginning, the major threat to the industry in individual litigation rested on the prospect of blockbuster punitive damage awards, particularly in view of the elderly profile of most tobacco disease victims (for out-of-pocket economic loss). But state tort reform caps on punitive damages, along with recent constitutional due process limitations imposed by the U.S. Supreme Court, have diminished the enthusiasm of plaintiffs' attorneys to take on these highly-contested, case-by-case battles against the industry.[67]

Moreover, one can construct a plausible scenario of diminishing prospects. The individual responsibility burden on the victim is a constant — indeed, perhaps a somewhat more substantial burden as pervasive health-risk information comes closer to corresponding to the entire time-span in which tobacco plaintiffs smoked, and the activity of smoking itself comes to be viewed as increasingly marginalized. At the same time, on the industry side, the potent assignment of wrongdoing for deceit and misrepresentation revealed in the mid-1990s recedes into the past as the MSA-related documents take on a historical flavor.[68]

From a still broader perspective, as I noted in earlier work, the tort litigation runs on a separate track from the panoply of other tobacco control initiatives.[69] In that regard, informational initiatives have been closely partnered with public-place smoking bans and point-of-sale limitations; excise tax increases have been leveraged in the public mind by health-risk information. But the tort litigation, apart from a complementary role in generating the narrative of

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66 *See id.*; Rabin, *supra* note 1, at 1741-44; Aaron Twerski & James A. Henderson, Jr., *Reaching Equilibrium in Tobacco Litigation*, 62 S.C. L. Rev. 67, 80-81 (2010).

67 Thirty-two states have instituted punitive damages reforms. Am. Tort Reform Ass'n, Tort Reform Record (2005), *available at* http://www.atra.org/sites/default/files/documents/Record7-05.pdf. The most recent leading U.S. Supreme Court cases establishing constitutional due process constraints are *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408 (2003); and *Philip Morris USA v. Williams*, 549 U.S. 346 (2007).

68 For a somewhat similar perspective, see Twerski & Henderson, *supra* note 66, at 76-95.

69 *See* Rabin, *supra* note 1, at 1747-49.

industry wrongdoing, does not have synergy with any of the principal tobacco control strategies in the public policy arena. It stands on its own.

Indeed, somewhat perversely from a tobacco control perspective, tobacco litigation — which from the outset in the mid-1950s was associated primarily with *tort* litigation — has currently taken a distinct turn to constitutional litigation. Rather than a sword in the hands of tobacco disease victims, it has come to serve as a shield employed by the industry to defeat limitations on promotion and advertising.[70] This will become still more evident as I now turn directly to the topic of initiatives aimed at restricting industry advertising and promotional strategies.

E. Advertising and Promotional Limitations

For most of the twentieth century, tobacco advertising flourished in every channel of mass communication — radio, television, and film; magazine, newspaper, and billboard.[71] Regulation was unknown. The first major inroad was the Federal Communications Commission (FCC) fairness doctrine, adopted in 1967, requiring that the industry provide the equivalent of its advertising time for counter-advertising of health-risk messages.[72] The aftermath, as noted above, was a congressional ban on broadcast media advertising, supported by an enervated tobacco industry.[73] Not surprisingly, this sequence occurred on the heels of the widely-publicized initial Surgeon General's Report on the health risks of smoking.

But the industry was quick to respond. It concentrated advertising and promotion priorities on print media, billboards, and outdoor recreational events: the Marlboro Man and Joe Camel came to characterize this period.[74] Once again, this new set of industry initiatives triggered responses on the regulatory front. Billboard advertising came under attack; albeit in a major court opinion a Massachusetts ban on this form of outdoor advertising was struck down as overreaching.[75] But the industry partially relented in the MSA: along with the substantial damage award mentioned earlier, the industry agreed to refrain from billboard advertising, using cartoon characters in advertisements, and

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70 *See* text accompanying *supra* notes 41-49.
71 *See* Proctor, *supra* note 55, at 56-87.
72 *See supra* note 37.
73 *See supra* note 37.
74 Proctor, *supra* note 55, at 80-82.
75 Lorillard Tobacco Co. v. Reilly, 533 U.S. 525 (2001).

a variety of promotional activities associated with sporting events.[76] Print media advertising also largely fell by the wayside.

Nonetheless the industry remained resourceful. These last restrictions ushered in a pronounced shift in priorities to the retail environment, proceeding on two tracks: point-of-sale promotions and price/premium discounting activities.[77] The industry invests heavily in these marketing activities: in 2010, advertising and promotion expenditures amounted to $8,046,000,000, and in 2011, $8,360,000,000.[78]

A recent report describes the promotional side of these activities:

> The largest portion of the tobacco companies' point-of-sale promotional budget is spent on price discounting, but a significant amount of that money is spent on "promotional allowances" that compensate retailers for prominently displaying tobacco products in specially designed display racks. In return for receiving these allowances, the tobacco retailers are typically required to sign contracts in which they commit to displaying a company's cigarettes and other tobacco products in a particular location and in a particular manner — usually in a power wall right behind the cash register.[79]

These promotional allowances — referred to in the trade as "slotting fees" — designed both to raise customer awareness and correspondingly stimulate on-the-spot purchases, are carefully crafted agreements featuring detailed specifications of height and visibility. In addition to product placement itself, these arrangements traditionally come with product accessories such as display racks and signage.[80]

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76 Iom Report, *supra* note 19, at 51, 123; *see also* U.S. v. Philip Morris, 449 F. Supp. 2d 1 (D.D.C. 2006), *aff'd in part & vacated in part*, 566 F.3d 1095 (D.C. Cir. 2009) (per curiam), *cert. denied*, 130 S. Ct. 3501 (2010) (holding tobacco companies liable for violating the Racketeering Influenced and Corrupt Practices Act (RICO) by fraudulently withholding information about health risks associated with smoking and for marketing to children).

77 Despite the restrictions imposed by the MSA, cigarette advertising remains ubiquitous in grocery stores, convenience stores, and bars. *See* Office of the Surgeon Gen., *supra* note 4, at 542.

78 Fed. Trade Comm'n, Cigarette Report for 2011 (2013).

79 Ctr. for Public Health & Tobacco Policy, Tobacco Products Display Restrictions 24 n.6 (2010), *available at* http://publichealthlawcenter.org/sites/default/files/nycenter-syn-tobproductdisplaybans-2013.pdf.

80 For a more detailed account, see IOM Report, *supra* note 19, App. L.

Here, too, there has been pushback by the regulators, but once again First Amendment and preemption limitations have loomed large. In *Reilly*,[81] the Supreme Court struck down a number of state point-of-sale limitations, such as proscribing placement less than five feet from the floor of the store, along with the ill-fated billboard ban. Only a ban on self-service displays was upheld, on the ground that it was aimed solely at product placement — seeking to deter theft of tobacco products by underage minors.[82] Just how long a shadow is cast on point-of-sale limitations is indicated by the Court's assertion in *Reilly* that "a distinction between state regulation of the location as opposed to the content of cigarette advertising has no foundation in the text of the pre-emption provision."[83]

In light of *Reilly* and the related expansive readings of commercial free speech limitations, the proposal of New York City Mayor Michael Bloomberg to require that cigarette products sold in retail establishments be hidden from view is highly suspect constitutionally.[84] While it is not clear where the line between promotional content and sales activities lies, municipalities have a narrow margin given the double bind of express preemption and lurking First Amendment concerns.

The dominant current thrust of promotional activity has been in the domain of price/premium discounting. In a recent assessment, a Federal Trade Commission report found, as mentioned, that the tobacco industry spent $8,360,000,000 on promotion and advertising in 2011, nearly eighty-four percent of which was allocated to price discounts to wholesalers and retailers.[85] This category merges with that just discussed: the price discounts are frequently negotiated with retailers along with provisions for how the discount information will be displayed at the retail sales counter. The discounting activities take a number of forms: straightforward buy-one-get-one-free offers and redeemable coupons; rebates and volume discounts (to the vendor). A wide array of other stratagems, including free samples, giveaways of non-tobacco products, and mail-order sales were also once extremely popular, but have been precluded by the 2009 federal tobacco act.[86]

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81 Lorillard Tobacco Co. v. Reilly, 533 U.S. 525 (2001).

82 In fact, merchants are more than willing to comply with this proscription out of precisely the same concern.

83 *Reilly*, 533 U.S. at 551.

84 *See* Anemona Hartocollis, *Bloomberg's Plan Would Make Stores Conceal Cigarettes*, N.Y. Times, Mar. 19, 2013, at A20.

85 Fed. Trade Comm'n, *supra* note 78.

86 Family Smoking Prevention and Tobacco Control Act (FSPTCA), Pub. L. No. 111-31, 123 Stat. 1776, 21 U.S.C. § 387a-1 (2009). Aside from the Act, there are additional restrictions on mail order, primarily designed to stop cigarette tax

Importantly, the FSPTCA does not set a ceiling on sale and distribution restrictions: states and localities are explicitly allowed to adopt more stringent standards. Indeed, on that score, a number of states have resorted to the adoption of minimum price provisions.[87] But of course, there is the persistent question of the constitutionality of these state restrictions. Nonetheless, there is persuasive argument that pricing restrictions do not raise First Amendment issues of the sort triggered by restrictions on advertising and promotion, and as long as the restrictions remain local in scope, any concern about burdening interstate commerce may be avoided, as well.

III. Focusing on Youth Prevention

In 2008, when I last addressed the strategies for moving forward in reducing youth smoking, I discussed the progress New York City had made by recourse to a set of initiatives that emphasized raising the excise tax, proactively promoting health-risk messages, and vigorously enforcing retail enforcement of the ban on sales to minors.[88] At that point, the city tax was $1.50 per pack, which, combined with a state tax of $2.75, constituted the highest city-state excise tax in the nation.[89] Along with this substantial tax burden, as mentioned earlier, the city pursued an active media campaign, focused on emphasizing graphic messages of the health consequences of tobacco disease.[90] And

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evasion, for example, Prevent All Cigarette Trafficking Act of 2010 (PACT), Pub. L. 111-154, and major courier agreements not to ship cigarettes. For a PACT summary, see *The PACT Act, Preventing Illegal Internet Sales of Cigarettes & Smokeless Tobacco*, Ctr. for Tobacco-Free Kids (Mar. 31, 2010), http://www.tobaccofreekids.org/research/factsheets/pdf/0361.pdf. For a press release regarding restricting cigarette shipments, see Press Release, N.Y. Attorney Gen. Office, Fedex To Strengthen Policies Restricting Cigarette Shipments (Feb. 7, 2006), *available at* http://www.ag.ny.gov/press-release/fedex-strengthen-policies-restricting-cigarette-shipments.

87 *See* Tobacco Control Legal Consortium, Tobacco Coupon Regulations and Sampling Restrictions 10 n.10 (2011), *available at* http://publichealthlawcenter.org/sites/default/files/resources/tclc-guide-tobcouponregsandsampling-2011.pdf (citing Ctrs. for Disease Control & Prevention, *State Cigarette Minimum Price Laws — United States, 2009*, 59 Morbidity & Mortality Wkly. Rep. 389 (2010)). Current New York City proposals include a minimum price requirement of $10.50 per pack.

88 Rabin, *supra* note 1, at 1766-68.

89 My field observations at that time indicated a retail sales price of about $7.50 per pack.

90 Rabin, *supra* note 1, at 1767.

contrary to a generally lax national pattern of retail inspections for violations of sales-to-minor laws, New York City invested heavily in sting operations.[91] Taken in tandem, the results were dramatic: an estimated smoking rate of 8.5% among teenagers, compared to national data reporting youth smoking of twenty-three percent in the same age cohort.[92]

Since then, the New York City youth smoking data suggest a loss of forward momentum: the youth smoking rate appears to hover around 8.5%.[93] While the city cannot stand as a proxy for the rest of the nation, it is nonetheless generally suggestive to explore what might account for the loss of momentum, and correlatively, to note the current efforts being taken to further reduce the youth smoking rate.

Why the leveling off of the teen smoking rate? Officials suggest two principal factors. First, the counterstrategies of the industry on the pricing front, discussed earlier: resort to a variety of discounting stratagems.[94] And second, a substitution phenomenon in which youths in the city intermix cigarette smoking with e-cigarettes, cheaper small cigars, and Snus; i.e., a relatively new phenomenon of teen smokers as dual users.[95]

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91 *See* Anthony Ramirez, *Teenagers in the City Smoke Less, Report Finds*, N.Y. Times, Jan. 3, 2008, at B3. In 1992, Congress had enacted the Synar Amendment, 42 U.S.C. § 300x-26 (West 2008), requiring all states to enact and enforce youth access laws and providing block grants to support the efforts. Despite this initiative, which was implemented with regulatory performance goals, enthusiasm elsewhere for high-intensity enforcement at the state and local level did not materialize. *See* Rabin, *supra* note 1, at 1755-57.

92 N.Y. City Dep't of Health & Mental Hygiene, New York City Youth Risk Behavior Survey (2007); IOM Report, *supra* note 19, at 53 (reporting on 2005 data).

93 *See* Hartocollis, *supra* note 84. At the same time, national reporting is more encouraging, *see* Dooren, *supra* note 8.

94 *See* text accompanying *supra* notes 79, 85-86. As the earlier discussion suggested, these tactics appear to be widespread, rather than limited to New York City.

95 Telephone interview with Kevin Schroth, *supra* note 16. (Snus are a moist powder tobacco substance, a variant on dry snuff, consumed by placement under the upper lip.) There is no reason to think that product substitution/intermixing is distinctly a New York City development. *See, e.g.*, Campaign for Tobacco-Free Kids, New Report: Tobacco Companies Exploit Regulatory and Tax Loopholes to Market Cheap Sweet Cigars That Entice Kids (2013), *available at* http://www.tobaccofreekids.org/what_we_do/industry_watch/cigar_report/. On the growing popularity of electronic cigarettes, which offer nicotine delivery through a vaporized (often flavored) mist, see Liz Alderson, *E-Cigarettes Are in the Vogue and at a Crossroads*, N.Y. Times, June 13, 2013, at B1. Substantial concerns have been raised that e-cigarettes may serve as a gateway to increased

What current efforts are being taken to regain momentum? The cornerstone strategy of further increasing the excise tax rate has been put on hold for the present. While the 2012 Surgeon General's Report documents (and underscores) the efficacy of the tax strategy, it appears to have run its course in the city, based on both fairness and political considerations. Again, it is critical to emphasize that at a certain point tax increases are tantamount to a ban — not just on youth smoking, but on adults as well. Fairness considerations regarding adult smokers are particularly highlighted by the regressive character of the excise tax in the context of a predominantly low-income smoking population. And correspondingly, as prices increase, there is the public health concern indicated earlier, as well — that adults may be allocating an inordinate amount of limited personal income to maintaining their smoking habit.[96] As a trumping counter-consideration for New York City, however, smoking prevalence among youth is particularly sensitive to price increases. In a direct counter to the industry's discounting tactics, New York City is considering a minimum price requirement of $10.50 per pack.[97] While a number of states have such a requirement, in virtually all instances the provisions are seriously compromised because discounting promotions are exempted; not so in the city proposal — and the $10.50 minimum also would be substantially higher than elsewhere.

On the educational front, the city has continued its strong emphasis on public health risk information. Content-wise, the messages maintain a focus on "shocking" images, showing smoking-related suffering and family impact, and are accompanied by contact information about a New York City-sponsored cessation-help line.[98] Mirroring the ill-fated FDA effort to impose on the industry a requirement of graphic images on the cigarette package, New York City adopted a regulation that required posting health warnings in retail establishments — only to have the requirement struck down, as indicated earlier, on preemption grounds.[99]

Undaunted, retail point-of-sale measures remain a focal point. The city has recently proposed a regulation that would require retail establishments

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youth smoking of conventional cigarettes. *See* Sabrina Tavernise, *A Hot Debate Over E-Cigarettes as a Path to Tobacco, or From It*, N.Y. Times, Feb. 23, 2014, at A1. And new products aimed at the youth market continue to crop up. *See* Matt Richtel, *E-Cigarettes, by Other Names, Lure Young and Worry Experts*, N.Y. Times, Mar. 5, 2014, at A1.

96 *See* Farrelly, *supra* note 24.

97 *See* Tobacco Control Legal Consortium, *supra* note 87.

98 Telephone interview with Kevin Schroth, *supra* note 16.

99 *See* 23-34 94th St. Grocery Corp. v. N.Y. City Bd. of Health, 685 F.3d 174 (2d Cir. 2012).

to ban display of cigarettes at the retail counter.[100] While this may avoid a preemption bar — if the courts characterize it as a time, place or manner limit rather than a promotional restriction — the increasingly expansive First Amendment protection for commercial advertising raises serious doubts about the constitutionality of this provision.[101] In addition, the City has on the drawing board new strategies that include attacking promotions which are based on discounts in price (e.g., buy a pack and get one free, or get Snus free with a pack of cigarettes) and prohibiting sales of low-priced cigars in packs of four or less.[102]

No legal impediments seem to shadow the third principal pathway the city has pursued: vigorous enforcement of retail bans on sales to minors. The New York City Department of Health partners with the Department of Consumer Affairs in running sting operations, and is currently looking to increase the penalties for violations.[103] In tandem with this effort, the city has raised the minimum legal age of smoking to twenty-one.[104]

Through these various stratagems, the city attempts to reinvigorate a downward spiral in smoking, especially among the young.[105] Despite the uncertainty about the fate of graphic warning requirements, the federal government now plays a complementary role: the federal excise tax has been substantially increased; coupon promotion has been proscribed, along with other giveaway and accessory schemes; flavored cigarettes (apart from menthol) have been banned — and to my mind, the most potent potential

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100 Hartocollis, *supra* note 84.

101 *See* text accompanying *supra* notes 41-49.

102 Under the proposed New York City rule, cheap cigars (three dollars or less) and cigarillos must be sold in packs of at least four, and little cigars must be sold in packs of twenty for no less than the price floor of $10.50. Telephone interview with Kevin Schroth, *supra* note 16.

103 *Id.* Under Family Smoking Prevention and Tobacco Control Act (FSPTCA), Pub. L. No. 111-31, 123 Stat. 1776 (2009), the FDA is authorized to provide funding support to states and localities to bolster this enforcement strategy. New York City is not a recipient of funds at this point.

104 *See* Anemona Hartocollis, *New York Raising Age to Buy Cigarettes*, N.Y. Times, Oct. 30, 2013, at A21.

105 Other proactive communities follow suit. In California, for example, it is estimated that 120 cities now have licensing ordinances imposing retail location density restrictions and a growing number of localities ban smoking in multiunit housing. Telephone interview with Ian McLaughlin, Senior Staff Attorney and Program Director, ChangeLab Solutions (Mar. 28, 2013).

initiative, ratcheting down the nicotine content of cigarettes, is an agency option under the FSPTCA, although apparently not on the current action agenda.[106]

IV. Another Vantage Point: Tobacco Control Strategies and the Obesity Problem

From a public health perspective, it may be useful to give brief consideration to the more general applicability of the framework of tobacco control initiatives, discussing the question whether the successes in this area of public health have carryover prospects beyond the concern for reducing smoking prevalence. I will limit this inquiry to the public health concerns arising from obesity. These concerns are positioned with tobacco as a primary area of need for identifying effective public policy initiatives.

The urgency and magnitude of the obesity problem is beyond dispute. According to the Centers for Disease Control (CDC), more than one-third of

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106 FSPTCA, 21 U.S.C. § 387g(a)(4)(A)(i). The Act does not allow for total elimination of nicotine. *Id.* § 387g(d)(3)(B). The ratcheting down strategy, which would of course directly address the addictive character of cigarettes, was forcefully advocated two decades ago in Neal L. Benowitz & Jack E. Henningfield, *Establishing a Nicotine Threshold for Addiction: The Implications for Tobacco Regulation*, 331 New Eng. J. Med. 123 (1994). Taking account of the Tobacco Act, the authors reassert their position in Neal L. Benowitz & Jack E. Henningfield, *Reducing the Nicotine Content to Make Cigarettes Less Addictive*, 22 Tobacco Control, Supp. 1 i14 (2013), offering evidentiary rebuttal to the principal behavioral concern that smokers would counter by engaging in compensating behavior through smoking down to the very edge of the product. *See also* Richard Daynard, *Regulatory Approaches to Ending Cigarette-Caused Death and Disease*, 39 Am. J.L. & Med. 290 (2013). A ban (or limit) on menthol-flavored cigarettes is another regulatory option left open to the FDA when Congress banned other flavorings in the FSPTCA. And in July 2013, the agency published a preliminary assessment of potential regulatory action in this regard, soliciting public comments. While there is no scientific evidence of greater health risks associated with menthol, it is considered a gateway to youth smoking and an impediment to quitting. The issue is politically sensitive: about eighty percent of African-American smokers prefer menthol cigarettes, and Newport, a menthol brand, accounts for ninety percent of Lorillard Tobacco sales. *See* Jennifer Corbett Dooren & Mike Esterl, *Menthols Could Increase Addiction Risk*, Wall St. J., July 24, 2013, at A3; Sabrina Tavernise, *F.D.A. Closer to Decision About Menthol Cigarettes*, N.Y. Times, July 24, 2013, at A15. A variety of "endgame" strategies directed at tobacco use are discussed in Symposium, *The Tobacco Endgame*, 22 Tobacco Control, Supp. 1 (2013).

adults and almost seventeen percent of youth are obese.[107] By contrast, data between 1960 and 1962 reported only 13.4% of adults as obese.[108] While the rate of increase may have slowed in recent years, there has been no progress towards reducing obesity rates to the CDC's goal of fifteen percent.[109] The health effects of obesity are undisputed and include high blood pressure, high cholesterol, Type 2 diabetes, coronary heart disease, and other problems.[110] As with tobacco, the aggregate impact of individuals dealing with the health consequences of obesity imposes a substantial burden on society. Treating obesity-related health conditions costs the United States over $100,000,000,000 each year.[111]

Viewing obesity through the lens of tobacco control reveals the complexity of employing similar tactics to achieve similarly successful outcomes — and at the same time, highlights the underlying factors that have animated notable reduction in smoking prevalence. As a starting point, consider the *informational initiatives* that contributed to the early inroads into smoking prevalence. Three particular "moments in time" — the Reader's Digest "health scare" of the early 1950s, the initial Surgeon General's Report in 1964, and the Environmental Protection Agency (EPA) report on the health risks of

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107 Ctrs. for Disease Control, Prevalence of Obesity in the United States, 2009-2010, NHS Data Brief 82 (2012), *available at* http://www.cdc.gov/nchs/data/databriefs/db82.pdf. Obesity is measured using an individual's "body mass index" (BMI), which factors in weight and height, but does not directly measure body fat. Adults with a BMI of thirty or greater are considered obese while those with a BMI of twenty-five or greater are considered overweight. *Defining Overweight and Obesity*, Ctrs. for Disease Control, http://www.cdc.gov/obesity/adult/defining.html (last updated Apr. 27, 2012). Children are considered obese if their BMI is at or above the ninety-fifth percentile for children of the same age and sex. *Basics About Childhood Obesity*, Ctrs. for Disease Control, http://www.cdc.gov/obesity/childhood/basics.html (last updated Apr. 27, 2012).

108 Cynthia L. Ogden & Margaret D. Carroll, Nat'l Ctr. for Health Statistics, Prevalence of Overweight, Obesity, and Extreme Obesity Among Adults: United States, Trends 1960-1962 Through 2007-2008 (2010), *available at* http://www.cdc.gov/nchs/data/hestat/obesity_adult_07_08/obesity_adult_07_08.pdf.

109 Ctrs. for Disease Control, *supra* note 107.

110 Nat'l Insts. of Health, Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report (2008), *available at* http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf.

111 *Id.* at vii. For more on the costs associated with obesity, see Eric A. Finkelstein et al., *Annual Medical Spending Attributable to Obesity: Payer and Service-Specific Estimates*, 28 Health Aff. 822 (2009).

secondhand smoke in 1986 — were especially salient.[112] By contrast, while recent years have certainly brought incremental growth in awareness of the obesity problem, there appear to be no comparably singular informational markers of insidious health consequences in the public mind.

Why might that be the case? Arguably, one contributing factor is that the sense of urgency associated with a public health problem is greatly enhanced when the health effects can be linked to a single identifiable source; in other words, a blameworthy entity. As discussed, the tobacco companies have assumed that unenviable position over the past twenty years, as correlatively has their product. Despite some media and print efforts to similarly label fast-food purveyors, no comparably censurable target has emerged.[113]

A second contributing factor might well be that health-risk information, once generated, is more likely to be acted upon by "elites"; that is, higher socioeconomic/educational status types. And indeed, tobacco use was pervasive across social classes a generation ago, with by far the greatest subsequent reductions in prevalence among those of higher socioeconomic and educational status.[114]

A third contributing factor can be identified in the third-party effect of health-risk information related to secondhand smoke exposure. Here, the impact of informational initiatives intersects with public place restrictions. As discussed earlier, those restrictions have not only created a protective barrier for nonsmokers, but also directly impacted smoking habits, by greatly reducing the opportunities for experiencing the positive enjoyment associated with smoking, both in the workplace and in public places of recreation.[115] Since there is no comparable third-party effect associated with obesity, once again there is no similar carryover from health-risk information.

A fourth potentially contributing factor, direct-to-consumer health-risk information, poses a less sharp distinction. Just as cigarette packages carry warning labels, a wide array of food products provides information on calorie and fat content.[116] Moreover, there are indicia of similar initiatives in dining

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112 *See supra* notes 31-37 and accompanying text.

113 For media and print efforts, see, for example, Super Size Me (Roadside Attractions 2004) (documentary film on McDonald's); Eric Schlosser, Fast Food Nation: The Dark Side of the All-American Dream (2003) (nonfiction account of health risks of fast food diet).

114 *See* Ctrs. for Disease Control & Prevention, *supra* note 6.

115 *See* text accompanying *supra* note 30.

116 *Food Label Helps Consumers Make Healthier Choices*, Food & Drug Admin., http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm094536.htm (last updated Apr. 26, 2013) (labels include information about a product's net weight, ingredients, and nutritional content).

establishments: New York City's requirement that fast-food establishments post calorie counts on menus is a leading example.[117] But even in this sphere of health-risk information there is a significant difference in the *content* of warnings: the tobacco package warnings make direct reference to the diseases associated with smoking. By contrast, product and purveyor warnings of health risks associated with obesity are far more indirect: whether consumers count calories, or indeed see a direct link between fat and calorie content on the one hand, and diseases such as diabetes and cardiac risk on the other, is highly debatable.

Turning to a second dominant tobacco control strategy, *public place restrictions*, there is total divergence in potential efficacy between smoking and obesity control. Not only have public place restrictions flourished in the tobacco area, but it is flat-out illegal to supply the product to minors under the age of eighteen.[118] To the contrary, public place restrictions have been absent as an instrument of obesity control. There are no comparable restrictions on places of consumption of fast-food products. Indeed, minors are particularly attracted both to fast-food establishments and to sugared retail food products that potentially create serious health risks. The decisive factor here, as just discussed, is the third-party effect that served as the principal lever for public place limitations in the tobacco area, with no counterpart in the case of obesity-related food consumption.

Finally, among the most successful smoking reduction initiatives is the *excise tax*. The tobacco tax falls on a single product, so the strategy has a well-defined focal point. Correlatively, the distributional consequences are clear. It is smokers who bear the tax burden, consistent with the rationale for the initiative: to create a focused incentive to quit. Taxation as an instrument of obesity control is far more complex. To begin with, there is a wide array of products that arguably contribute to the obesity problem. And the problem itself can be viewed as much a consequence of purveyor activity as of product supplier activity. Hence the appropriate sources of tax incidence are less clear. Moreover, there is a significant spillover effect. While the tobacco excise tax falls on those whose health is compromised (smokers), any excise tax on an obesity-related food product or purveyor enterprise would impact a significant population of individuals who are not particularly at risk health-wise.[119]

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117 Bd. of Health of N.Y. City, Notice of Adoption of An Amendment (§ 81.50) to Article 81 of the N.Y. City Health Code, adopted Dec. 5, 2006 and codified at N.Y. City Health Code § 81.

118 *See* Rabin, *supra* note 1, at 1755-57.

119 A tax on alcoholic beverages similarly has spillover effects on a risk-free population. But alcohol is a luxury item, unlike food products that are staple

These distinctions — making obesity harder to control through policy intervention — apply even to the somewhat less successful measures in the tobacco control area. In the *tobacco tort litigation*, the tobacco companies continue to stymie efforts to achieve any substantial threat to the viability of the industry, as assumed risk remains a fairly reliable defense to injury claims.[120] But a half century of litigation costs, and the multibillion dollar MSA, have certainly created some upward pressure on price. Moreover, the litigation did play a contributing role in exposing the narrative of industry deceit and misrepresentation that sharply redefined the industry's image, with real political costs.

By contrast, tort litigation cannot effectively play a role in reducing obesity. The McDonald's litigation, if anything, heaped scorn upon the plaintiffs rather than the fast-food enterprise.[121] Causation is a powerful barrier to the affirmative claims and assumed risk is a similar obstacle from a defense perspective. As a consequence, litigation costs are likely to remain minimal unless some "smoking gun" (along the lines of tobacco company internal memos) is unearthed. While there has been a spate of books and films vilifying the fast-food purveyors and the culture of large portion-size, these remain too far-removed from the litigation forum to overcome the doctrinal obstacles just mentioned.

Restrictions on advertising raise a different set of considerations. Common to both tobacco and obesity, First Amendment restrictions on limiting commercial advertising must be factored into any governmental initiatives.[122] But constitutional issues aside, a critical background consideration is especially significant in the advertising and promotion area: the illegality of tobacco use by minors. As a consequence of this illegality, direct efforts by the tobacco companies to encourage youth smoking are prohibited.[123] In sharp contrast, there is no similar adult/minor dichotomy in the food advertising domain:

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consumption goods.

120 *See* text accompanying *supra* note 64.

121 *See generally*, Michelle M. Mello, Eric B. Rimm & David M. Studdert, *The McLawsuit: The Fast-Food Industry and Legal Accountability for Obesity*, 22 Health Aff. 207 (2003) (discussing the controversial reaction — much of it negative in tone — to lawsuits brought against McDonald's alleging a causal connection between overweight conditions of plaintiffs and consumption of McDonald's food products).

122 *See generally* Cent. Hudson Gas & Elec. Co. v. Pub. Serv. Comm'n, 447 U.S. 557 (1980); text accompanying *supra* notes 41-49.

123 Indeed, a principal feature of the mid-1990s revelations of tobacco industry misfeasance was the evidence of *indirect* efforts to encourage youth smoking through a variety of advertising strategies. *See* Proctor, *supra* note 55.

not only is advertising targeting the youth market legal, it is pursued with vigor through the marketing and promotion of sugar-coated cereals, candy bars, Ronald McDonald, and so on.

Finally, in this brief comparative survey, there is the youth market; more particularly, *youth access restrictions*. Following on what I have just noted, legality/illegality is the critical factor here. Tobacco regulation derives substantial support from the mandatory ban on sales to minors. Even if poorly enforced (traditionally), product access restrictions that operate in a supply-side fashion (penalizing vendors for sale to minors) are another tool, along with those already described, in discouraging smoking behavior — both initiation and habituation. The restriction comes into play at an age (one's early teens) when the binary character of the health risk — one smokes or does not smoke, one is at risk or not at risk — is manifest. The risk of obesity is far more insidious. It arises at a very early age and it grows incrementally, rather than having a binary character. As a consequence, the controls are far more parent-mediated, rather than calling into play governmental initiative, although school-age programs potentially do play an important role.[124]

V. Concluding Thoughts

Beginning in the mid-1960s, tobacco control strategies — principally, provision of health-risk information, prohibition of smoking at work and in places of public entertainment, and increases in state excise taxes — dramatically reduced smoking prevalence. But more recent data on tobacco use indicate that the downward trend has notably diminished, animating antismoking advocates to reinvigorate efforts aimed at further reducing smoking prevalence.These efforts have placed particular emphasis on youth smoking — since smoking in the teenage years is the gateway to long-term smoking and its related correspondence to long-latency, smoking-related diseases.

New York City's vigorous campaign against youth smoking has served as a model for the current initiatives, building on past strategies through a multipronged approach: proactive enforcement of bans on sales to minors (among other stratagems, raising the minimum age of purchase), restrictions

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124 On school-based programs, see generally Inst. of Med., Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation (2012) (among other proposed goals, making schools a focal point for obesity prevention through physical education, health information, and nutritional food programs). The Obama administration is taking an active role in this area. *See, e.g.*, Ron Nixon, *U.S. Standards for School Snacks Move Beyond Cafeteria to Fight Obesity*, N.Y. Times, June 29, 2013, at A18.

on point-of-sale advertising and placement, reliance on graphic health-risk warnings, and resort to closing loopholes aimed at evasion of the excise tax.

The singular efficacy of these strategies in reducing smoking prevalence is highlighted by examining the complex issues raised by importing the framework to another area of major public health concern, reducing obesity. Tobacco controls have been grounded in a framework that has benefited from a sharply-defined etiology of risk, a narrative of unscrupulous industry conduct, and a shared consensus on the need to proscribe youth access. The framework and its foundation reveal a good deal of indeterminacy as a blueprint for public health strategizing on the obesity problem. And indeed, building on past successes continues to pose fresh strategic challenges in defining the course of further reductions in smoking prevalence.