CHEST Commentary

The Master Settlement Agreement and Its Impact on Tobacco Use 10 Years Later

Lessons for Physicians About Health Policy Making

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The issue of tobacco industry responsibility for population health problems and compensation for their treatment has been growing since the 1960s. In 1999, the state attorneys general collectively launched the largest class action lawsuit in US history and sued the tobacco industry to recover the costs of caring for smokers. In what became known as the Master Settlement Agreement (MSA), states were rewarded billions of dollars and won concessions regarding how cigarettes could be advertised and targeted to minors. Ten years after this settlement, much is known about how MSA monies were distributed and how states have used the money. There is some understanding about how much of the money went toward offsetting the health-care costs attributable to smoking and whether resources were allocated to efforts to reduce smoking in a particular state. However, there are few data on what effect, if any, the MSA had on tobacco control locally and nationally. This commentary explores these issues, as well as how the tobacco industry has evolved to offset the losses incurred by the settlement. Finally, an analysis of the complexities of current tobacco policy making is provided so that physicians and other health-care advocacy groups can more completely understand the present-day political dynamics and be more effective in shaping tobacco control policy in the future. ***CHEST 2010; 137(3):692–700***

Abbreviations: CDC = Centers for Disease Control and Prevention; FDA = Food and Drug Administration; MSA = Master Settlement Agreement

It has been nearly 10 years since the state attorneys general banded together in a concerted legal effort to recover the costs of caring for smokers who had developed cigarette-related illnesses. To avoid possible bankruptcy, tobacco industry companies agreed to a legal settlement known as the Master Settlement Agreement (MSA). With the MSA, states obtained a 25-year payout of hundreds of billions of dollars from "Big Tobacco." In addition, the tobacco industry was forced to make other concessions regarding how cigarette advertising and other products were targeted at youths, meant to decrease smoking nationwide. In return, the 46 states that were parties to the MSA agreed to drop their pending individual and collective litigation against the tobacco industry. The impact of the settlement is the subject of much debate. Here we look back at the MSA, how it was implemented, its possible impacts, and the lesson it provides physicians about health policy-making realities in the United States.

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Historical Perspective

The original purpose of the MSA must be put into the broader context of the history of the antitobacco movement in the United States. The use by states of MSA funds has evolved over the last decade, and this

evolution has been driven by shifting political and economic factors.

The history of antitobacco activism in the United States, and the efforts to limit the sale of cigarettes and their use, particularly by minors, began in the 1950s with initial epidemiologic research linking cigarette smoking to lung cancer.[1] The Surgeon General's report *Smoking and Health* received enormous publicity.[2] The resulting public awareness of the dangers of tobacco led to the beginning of a slow decline of overall cigarette consumption in the United States. This increased concern also resulted in some significant policy developments, including the 1966 requirement for warning labels on each package of cigarettes, and the 1971 ban on radio and television cigarette advertising.

Despite these marketing setbacks, the tobacco industry subsequently engaged in sophisticated and effective activities to limit the impact of antitobacco policy initiatives. Congress, influenced by tobacco industry lobbying, removed Federal Communication Commission Fairness Doctrine requirements for subsidized antitobacco advertising, while retaining the ban on radio and television tobacco advertising itself.[3] The net impact reduced the visibility of the antismoking drive, thus blunting its momentum.[4] The tobacco industry also defeated every lawsuit for damages brought against it by impaired and/or dying smokers and their family members, successfully contending that the cigarette package warning label (along with equivalent warnings on print advertising) adequately informed smokers of health risks, thus making them responsible for their own decisions to smoke.[5,6] Under American federalism, most health regulation is controlled by the states. Consequently, the tobacco industry was able to prevail against public health efforts by successfully keeping the locus of litigation and government regulation at the state level.[7] Public health advocates did not have the political clout at either the federal or the state level to make significant inroads into the tobacco industry beyond existing advertising bans and warning label requirements.

This legal situation was dramatically transformed in the 1990s, primarily by a loosely coordinated alliance of trial lawyers and state attorneys general. Avoiding the obstacles to success for litigation on behalf of injured individuals, they put forth a novel legal argument on behalf of the states in which smoking-damaged individuals lived. Given the rapidly growing costs of smoking-related illnesses, many afflicted individuals wound up receiving health care funded by the states through Medicaid. The states' taxpayers had not chosen to smoke but were forced to cover these enormous costs. Therefore, the states would sue the tobacco industry for recovery of Medicaid costs due to smoking-related illnesses.

Beginning in Mississippi in 1994, state attorneys general launched similar suits against the tobacco industry, three by the end of 1994, 17 by 1996, and 39 by 1997.[8] Evidence was uncovered that the tobacco companies had known for years about the damage caused by their product but had conspired to suppress the information. States then invoked Racketeer-Influenced Corrupt Organization statutes to multiply the sought damages to staggering levels, billions of dollars for each state.[9] Finally, as plaintiffs, the states could go beyond seeking monetary damages to requiring "equitable relief," demands for future restrictions on tobacco industry behavior.

Ultimately, the states, with the participation of the federal government, were able to impose regulatory restrictions on the tobacco industry through the courts, restrictions they had not been able to obtain during >40 years of prior legislative efforts. The tobacco industry, faced with the risk of financial ruin through an endless procession of state lawsuits, reluctantly agreed to what became known as the MSA. By February 1, 1999, the tobacco industry and 46 states, along with the District of Columbia and 6 US territories, had received trial court approval for the MSA.[10]

The MSA involves a massive financial transfer from cigarette manufacturers to the states for the cost of treating smoking-related illness, and for funding educational programs to reduce underage smoking (see Table 1 for highlights of the settlement). In addition to the MSA funds, four states that had settled with the tobacco industry prior to the MSA would receive $40 billion over the same 25-year period.[4] The MSA also created a nonprofit national foundation (the American Legacy Foundation) to support research on effective tobacco programs ($250 million over 10 years) and to fund an antismoking advertising campaign with a total of $1.45 billion over 5 years.[11] Lastly, a National Tobacco Grower Settlement Trust would provide $5.15 billion over 12 years to compensate tobacco quota holders and farmers for expected financial losses caused by a forecasted MSA-driven decline in cigarette consumption.

As noted above, the ostensible primary purposes for MSA funding to the states involved Medicaid services for smoking-related illnesses, and educational programs to reduce underage smoking. In the late 1990s, it was assumed that the states would be willing and able to spend the revenues on the stated purposes. After all, Medicaid was certainly a "budget buster" for all states, and required additional revenue. In other program areas, the states were benefiting from the booming "dot.com" economy of the decade, and most had budget surpluses.[12] The biggest

Table 1—*State Master Settlement Agreement Expenditures by Category (2006)*

State	Debt Service on Securitized Funds/ Budget Shortfalls	General Purposes, Including Education and Social Services	Health	Infrastructure/Economic Development, Including Tobacco Payments	Tobacco Control	Total
Alabama	13,000,000	89,891,152	45,449,837		530,690	148,871,679
Alaska	16,900,000	...	...	...	5,085,339	21,985,339
Arizona	...	...	89,553,200	...	...	89,553,200
Arkansas	5,000,000	2,337,289	27,230,395	...	14,932,316	49,500,000
California	401,637,000	...	...	...	...	401,637,000
Colorado	...	43,802,868	39,905,273	7,114,156	...	90,822,297
Connecticut	...	94,875,000	16,000,000	...	125,000	111,000,000
Delaware	...	6,160,000	16,849,500	...	4,684,500	27,698,000
Florida	...	...	...	...	...	No MSA
Georgia	...	7,149,804	99,148,370	47,123,333	3,205,245	156,626,752
Hawaii	...	12,613,376	13,694,619	10,955,695	4,890,935	42,154,625
Idaho	...	23,641,285	...	...	430,000	24,071,285
Illinois	...	50,344,072	238,414,550	7,602,749	12,917,900	309,279,271
Indiana	...	34,200,000	92,200,000	51,300,000	10,100,000	187,800,000
Iowa	43,680,000	5,484,535	68,517,227	...	5,011,565	122,693,327
Kansas	...	51,445,008	1,300,000	...	1,000,000	53,745,008
Kentucky	...	11,083,800	38,370,400	54,212,500	4,933,300	108,600,000
Louisiana	87,148,112	43,959,968	13,758,480	...	500,000	145,366,560
Maine	451,010	16,601,373	17,920,623	...	15,295,990	50,268,996
Maryland	...	33,052,000	104,362,000	5,956,000	9,230,000	152,600,000
Massachusetts	...	253,349,780	...	...	...	253,349,780
Michigan	...	166,686,800	122,300,000	...	...	288,986,800
Minnesota	...	...	...	...	...	No MSA
Mississippi	...	...	...	...	...	No MSA
Missouri	84,089,532	2,145,573	67,282,481	...	482,414	154,000,000
Montana	...	5,210,930	14,065,685	...	6,825,385	26,102,000
Nebraska	...	12,094,737	21,678,570	...	2,500,000	36,273,307
Nevada	...	22,434,987	12,523,141	...	4,528,847	39,486,975
New Hampshire	...	43,000,000	...	...	...	43,000,000
New Jersey	249,152,772	...	...	...	...	249,152,772
New Mexico	...	17,787,921	11,870,000	...	...	29,657,921
New York	434,741,632	...	...	...	...	434,741,632
North Carolina	1,979,096	36,000,000	40,245,278	7,038,310	15,000,000	100,262,684
North Dakota	...	10,337,430	229,721	10,337,430	2,067,486	22,972,067
Ohio	...	28,228,391	52,080,892	258,952,983	47,905,890	387,168,156
Oklahoma	...	5,845,788	32,649,026	...	15,199,277	53,694,091
Oregon	58,737,984	4,122,375	12,250,000	...	...	75,110,359
Pennsylvania	...	...	333,295,000	...	32,963,000	366,258,000
Rhode Island	47,988,000	...	...	...	...	47,988,000
South Carolina	74,329,662	...	...	...	...	74,329,662
South Dakota	17,167,994	15,005,263	...	...	...	32,173,257
Tennessee	...	153,000,000	...	...	...	153,000,000
Texas	...	...	...	...	...	No MSA
Utah	...	12,476,100	13,002,800	...	4,062,100	29,541,000
Vermont	...	737,000	21,233,111	...	5,132,698	27,102,809
Virginia	33,444,540	...	52,977,816	89,311,135	13,244,454	188,977,945
Washington	38,252,000	...	92,748,000	...	17,500,000	148,500,000
West Virginia	...	30,000,000	20,078,744	...	5,850,592	55,929,336
Wisconsin	138,929,751	...	...	...	...	138,929,751
Wyoming	...	3,228,981	6,918,275	...	5,680,236	15,827,492

Data are presented as US$. MSA = Master Settlement Agreement. (Adapted with permission from the Robert Wood Johnson Foundation and the Institute for Health Research and Policy, University of Illinois Chicago Circle, 2008.)

political issue in many states was how large a tax cut and/or rebate should be enacted. As Warner[4] noted, "For a brief historical moment, the air was filled not with smoke but with optimism that soon all states would mount credible, comprehensive tobacco control programs."

However, in 2000, the economy began to go into recession as the "dot.com" bubble burst, and stock markets indices dropped rapidly. On September 11, 2001, after the terrorist attacks on New York City and Washington, DC, the economy was further dampened by declines in tourism and air travel. The economy

began to pull out of the recession in 2003, but states that had cut taxes a few years earlier found that they did not have revenues adequate to meet major needs across all programs. Increasing taxes as a response would be politically dangerous for politicians who had gained or held office through the promise of reduced taxes. Inevitably, the temptation to treat MSA revenues as a "cookie jar" to be tapped for budget shortfalls was irresistible. Additionally, in tobacco-growing states, there were growing tensions between the goals of tobacco control and rural economic development, with some arguing that zealous efforts to reduce smoking would damage the tobacco industry, and thus rural employment and income.[13,14] In an overview examination of Congressional and state issues, an analyst noted that the MSA "does not address the question of state legislative appropriation of the settlement funds, nor does it earmark or in any way restrict how states spend the funds."[11] Because the MSA did not require the states to spend revenue on any specific activities, the way was clear for states to spread MSA revenues through their budgets according to their specific political and economic situations.[15]

Impacts of the MSA

The general consensus of researchers has been that the MSA has not significantly harmed the tobacco industry, especially when the growth in the international sales of US tobacco products is taken into account.[16] Smoking rates in the United States leveled off between 2004 and 2007, after a previous decade (mostly pre-MSA) of steady decline.[17,18] State tobacco control policy making became more activist and aggressive from the 1990s onward, but the tobacco industry was usually able to keep states from nonincremental regulatory changes.[19] Indeed, much state antitobacco policy activism in the first decade of the 21st century originated at the city level.[20]

In addition, many state antitobacco initiatives were countered by continued (and effective) efforts by the tobacco industry to market and advertise their products to minors.[21] Cigarette marketing to teens through magazine advertising in Massachusetts actually increased after the MSA took effect, although subsequent public and political pressure forced tobacco companies to reverse this.[22] There was also a post-MSA increase in externally visible cigarette advertising on retail storefronts in Massachusetts, an increase that has not been reversed, except in areas near schools.[23] Nationally, the tobacco industry reacted to the MSA with more aggressive marketing, including more expenditures on advertising, especially point-of-purchase cigarette advertising and promotions.[24,25] Direct marketing was accelerated via direct mail, coupons, sweepstakes, brand loyalty programs, event sponsorship, and tobacco industry magazines, avenues that were generally not bound by MSA guidelines.[26,27]

One particularly controversial practice was product placement of cigarettes and their use in movies, which often have high proportions of young viewers. A recent study suggested that approximately 390,000 teens start smoking each year because of smoking behavior they have seen in movies. It has been estimated that 89% of movies have at least some smoking images, and that the frequency of these images has increased significantly in recent years, including in PG-13 movies. One study concluded that tobacco product placement in movies has created an additional $4.1 billion in revenues and almost $900 million in extra profits for the US tobacco industry.[28,29]

In 2000-2001, the General Accounting Office conducted a detailed analysis of how states used MSA payments.[30] Their study concluded that "states have used their MSA payments for a variety of programs and budget priorities, including, but not limited to, tobacco control and health care programs." The General Accounting Office found that the largest allocation of MSA funds did go to state health-care programs, but the funds were not focused on smoking-related treatment or youth antismoking education. Seven states had allocated significant amounts of MSA money to tobacco grower assistance and general economic development. More than one-fourth (26%) of MSA money had been spent on non-health programs, including education and social services, infrastructure (roads, bridges, and so forth) and budget reserves. Fully 20% of MSA funds had not yet been allocated.

In one of the earliest studies of MSA impact, Gross et al[31] concluded that MSA funding did not have a significant effect on state tobacco control funding, primarily because only a modest proportion of MSA monies were going into relevant state programs. Others concluded that, by 2003, states were allocating 39% of their MSA funds to health care, including health services, tobacco-use prevention, long-term care, and biomedical research.[32] However, the percentage of funding for tobacco-use prevention declined to 3%, after being at 5% during 2000-2002. Because of an economic downtown, 36 states (twice as many as in 2002) were using tobacco revenue to support general state government funding.[32]

Another study of six states concluded that "a lack of strong advocacy from public health interest groups, an unreliable public constituency for tobacco control, and inconsistent support from state executive and legislative branches, all combined with sizable budget deficits" led to a decline in health spending with

MSA monies.[33] Interviews with tobacco control agencies led one research group to conclude that few MSA resources were being dedicated at the state level to tobacco control and prevention efforts in ethnic minority communities.[34] On the other hand, at times MSA funds have prevented even greater cuts in some health and antismoking programs made by financially strapped states.[35]

During 2001-2006, an increasing number of reports and anecdotal accounts suggested that a high percentage of MSA funding was being dissipated in areas that were far from the initial intentions of the agreement. A systematic study of news media coverage of MSA spending listed 29 different identified projects. Some were at least public health related (funding for health clinics and water systems in Montana and South Carolina, respectively). However, other coverage showed that the MSA was being used as a "cookie jar" for almost any and all state spending (eg, textbooks for parochial schools in Maryland and the purchase of laptop computers for legislators in South Carolina). The study concluded that general public perceptions of scattershot MSA spending were valid, and argued for increased caution in developing plans for use of the funds.[36]

The Campaign for Tobacco-Free Kids noted that only five states were spending MSA monies on youth antismoking programs at the 20% to 25% level recommended by the Centers for Disease Control and Prevention (CDC). Three states (Michigan, North Carolina, and Tennessee) spent no MSA money on antismoking measures.[37] Several states (including New York, California, and Connecticut) securitized all or some of their MSA revenue, selling their yearly MSA payments through the use of state-backed bonds.[38] They were then able to use the subsequent bond revenue to reduce current state deficits and/or increase funding in some areas.[35] The practice of securitization has been strongly opposed by tobacco control organizations.[39,40] By fiscal year 2008, only three states (Maine, Delaware, and Colorado) were funding tobacco-use prevention programs at the minimum level recommended by the CDC.[41]

More-detailed studies of individual states have generally confirmed these findings of mixed efforts and impacts. According to the Center for Tobacco Control Research and Education, tobacco policy making in California during 1999-2001 was "stalled and adrift,"[42] with the Davis Administration refusing to spend significant amounts of MSA funds for youth antismoking programs. However, others found that California's record has become much more positive in recent years, with considerable antitobacco policy making in the area of "smoke-free air," along with higher tobacco taxes and targeted youth antitobacco education.[25,43] In Massachusetts, a successful statewide antitobacco program in operation since 1992 faced serious budgetary problems by 2003 because the state was not willing to put a large proportion of its MSA funds into its continuance.[44] Reflecting agricultural and manufacturing interest group influence, North Carolina (like other tobacco-growing states) has allocated much more of its MSA funding to tobacco farmers and their communities than to tobacco control efforts.[45] More positively, the state has used MSA funds to support North Carolina's Fit Initiatives, a set of programs to reduce obesity.[46]

With respect to other states, a study of Arkansas found that the state has put a great deal of its MSA funds into antitobacco efforts, and all funds into health-related programs.[47] Initial antitobacco efforts in the state of Florida included a youth antismoking program. This effort was significantly reduced in 1999 after opposition was expressed by the incoming governor, Jeb Bush.[48] However, Florida did continue to put MSA monies into "truth" antitobacco countermarketing aimed at youth via television, radio, billboard, and World Wide Web advertisements.[49] The state of Texas was one of four states to settle its suit with the tobacco industry prior to the MSA, for $17.3 billion. From the money that the state had received by 2001 ($1.8 billion), only $30 million had been spent on tobacco control. Although some communities within Texas (including the cities of Austin and El Paso) have strong antismoking regulations, the tobacco industry has been very successful in limiting the use of additional state suit funding for any antitobacco initiatives.[50] Some idiosyncratic state expenditures with MSA money have prompted public outrage and ridicule, including those in New York ($700,000 for golf carts), Virginia ($12 million for laying fiber-optic lines for broadband cable), North Dakota (45% of its MSA allocation for water resources and flood-control projects) and Alabama (> $1 million for boot camps for juvenile delinquents, alternative schools, metal detectors, and public school surveillance cameras).[51]

The most recently available data on MSA spending by all states (2006) broadly confirm the above-mentioned patterns. As can be seen in Table 1, in most states, tobacco control spending is a small fraction of total MSA spending. In 15 states (Arizona, California, Colorado, Connecticut, Massachusetts, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, and Wisconsin), no MSA funds are spent on tobacco control. Health and "general purposes" spending (including education and social services) account for most MSA expenditures. Not surprisingly, given national economic difficulties and the political difficulties states have in either cutting budgets and/or raising taxes, many states have used MSA monies to close

budget deficits. Notably, two of the largest states (California and New York) have securitized all of their 2006 MSA funds. (It should be noted that four states [Florida, Minnesota, Mississippi, and Texas] do not have tobacco revenue disbursed via the MSA because, as noted earlier, they concluded their own legal settlements with the tobacco companies, containing different revenue payment arrangements.)

Overall, observers of the MSA implementation have suggested that the states have, at best, a "mixed record" when it comes to using the funds for originally intended purposes. Among health policy makers, there is a growing consensus that "the public lost a golden opportunity to improve its health" when the MSA was enacted.[52] One unintended positive consequence has been that since tobacco companies have passed along MSA costs to their customers in terms of higher prices per pack, teen smoking has declined somewhat.[53]

Policy Implications

In this analysis, it is important to note that tobacco control advocates assume that MSA-funded state initiatives will, in fact, be effective in reducing tobacco use and improving individual and community health status. That means that any study of MSA impact must also include an examination of state tobacco control policies. The most effective anti-youth-smoking efforts seem to combine increased MSA funding for tobacco control programs with additional cigarette tax levies, such as the $0.50 per package imposed by California in 1998.[54] Additional funding for televised antitobacco advertising may also be cost effective.[55]

Regardless of the source, there is significant evidence that comprehensive tobacco control programs do reduce smoking rates over an extended period of time, and that the longer such programs operate, the greater the positive impact.[56] The CDC has provided technical assistance to states to evaluate the impacts of their MSA-funded tobacco control efforts.[57] However, it is clear that the MSA has not resulted in a clear and straightforward intensification of state tobacco control efforts, because of the impact of interest group activity and changing economic situations at the state level; MSA resources have been significantly diverted from tobacco control and treatment into other state policy activities.[5]

The results of state tobacco control policy making, and the fate of MSA spending to date, can be explained largely by the realities of health policy making. First, policy making in the United States tends to be incremental. To enact new (or to change old) policies, advocates need to construct and maintain coalitions of interest groups, each of which will have its own imperatives and preferences.[58] Antitobacco advocates, who are often commendably zealous about reducing tobacco use and morally outraged by the intentions and activities of the tobacco industry, do not necessarily find the give and take of coalition politics (where the enemy of my enemy must at times be my friend) to be pleasant. At times, this intensity leads to reluctance to cut the deals necessary to get good things done. The criticism that much MSA spending gets diverted to non-tobacco control uses is valid but ultimately unproductive. As noted earlier, even diverted MSA monies can serve useful purposes in areas such as health and education. To be more effective, antitobacco activists need to accept this. The response to poor or less-than-ideal past state tobacco control policies is not to condemn political dealing. Rather, it is to learn how to cut better deals for one's own group.

Second, older, bigger, and more established groups are more likely to win in state health policy making than newer and smaller groups.[59] Once the MSA agreement established that MSA monies would not be "dedicated" (that they could be used in any way a state saw fit), the die was cast. MSA funds are "found money," and the most politically powerful groups are more likely to get their hands on them. Tobacco control advocates need to understand that, whatever their merits, their objectives, valid as they are, will usually be less important to state legislators than minimizing the need to raise taxes while satisfying the perennial major constituents for state spending, especially education and Medicaid. If tobacco control is to keep advancing, it will have to do so as a junior partner in alliance with institutional group interests such as these.

Third, in the early 21st century, almost all state policy making is driven by budgetary imperatives, that is, raising more money and/or finding ways to cut expenditures, in both cases while preferably minimizing political controversy and pain. Whatever their policy clout, the tobacco companies do not have a favorable public image. In addition, the overwhelming evidence is that the most important factor in reducing tobacco consumption (and in preventing young people from taking up the habit) is higher tobacco prices, including taxes.[60] Given this, tobacco control advocates need to spend the greatest part of their time and effort working with other groups to raise state tobacco taxes. The MSA is an important source of funds for tobacco control, but even if MSA revenues are used for purposes other than tobacco control, the resulting increased cost of tobacco products will itself significantly contribute to the goal of reduced consumption.

Finally, given the above three points, from a policy perspective it is clear that tobacco control advocates should continue to lobby for more MSA spending but

they should not overestimate the importance of such funds in the ultimate fight against tobacco. Children certainly do need to learn that they should not use tobacco, but it is more important to ensure that the price of tobacco products is so high that it is difficult for them to get them under any circumstances. MSA money can play a part in this, but it cannot and should not be the chief financial element in tobacco control policy. This realization can only strengthen tobacco control efforts at the state level.

Conclusion

It is clear that the MSA has not resulted in a clear and straightforward intensification of state tobacco control efforts, because of the impact of interest group activity and changing economic situations at the state level. MSA resources have been significantly diverted from tobacco control and treatment into other state policy activities.[59]

State tobacco control policy making has been evolving since the settlement was enacted. Over time, as general public opinion has become less supportive and tolerant of tobacco use, and as the costs in healthcare spending have become greater, state policies toward tobacco control have generally become more aggressive and restrictive. However, each state sets its own policies and possesses different economic, social, and environmental characteristics. As noted earlier, the MSA was also written to give states complete flexibility in the use of the awarded revenue. Therefore, it is very hard to separate out and measure the impact of specific tobacco control initiatives, including those associated with the MSA. Further research and critical analysis are needed to assess the individual impact of the MSA in relation to other efforts at tobacco reduction (eg, taxation, workplace initiatives, youth smoking programs, and so forth).

The most dramatic recent tobacco control initiatives have actually been at the federal rather than state level. Most notably, on June 22, 2009, President Obama signed the Family Smoking Prevention and Tobacco Control Act into law. This act gives the US Food and Drug Administration (FDA) authority to regulate the production and marketing of cigarettes and other tobacco products. One part of the law establishes the FDA Center for Tobacco Products, with a Tobacco Products Advisory Committee to provide guidance on possible regulations.[61] In its first major regulatory action on September 21, 2009, the FDA banned flavored cigarettes, declaring that they were a "gateway" for children and youths to pick up the smoking habit.[62] However, as with state tobacco control policy making, there are clear legal and political conflicts ahead between antitobacco and industry groups at the national level with respect to interpretation of the Family Smoking Prevention and Tobacco Control Act.[62] Politics marches on.

Those, including physicians, who are committed to greater public health through a continued reduction in the use of tobacco products must become more politically active and more realistic in their expectations of the resulting political outcomes. In the political arena, any entity committed to survival (and this most certainly includes the tobacco industry) will fight hard to fend off threats to its existence. The tobacco industry can only survive if it maintains its legal status and is able to market its products to adolescents who are not legally entitled to them, "hooking" them into lifetime tobacco consumption. Because tobacco is a lucrative and heavily taxed product, governments that both regulate tobacco and require tax revenue will always be ambivalent in their attitudes toward tobacco consumption and cessation.

Physicians must come to know their enemies as well as their patients, and realize that those enemies can only be defeated with a combination of continual political pressure and longer-range education that finally creates a society that has no room for tobacco. A "fierce urgency of now" in political activity must be combined with an infinite patience to educate a people and change a culture.

Highlights of the MSA Settlement

- A payment of $206 billion to the states, spread out over a 25-year time period
- A $1.5 billion payment over 10 years to support state antismoking measures
- A $250 million payment to fund research into reducing youth smoking
- Permanent limitations on cigarette advertising
- A ban on the use of cartoon characters (such as Joe Camel) in advertising
- A ban on cigarette "branded" merchandise
- Limits on tobacco industry sponsorship of sporting events (such as the Virginia Slims tennis tournament)
- The dissolution of tobacco trade organizations

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