The Political Evolution of Anti-Smoking Legislation

Peter D. Jacobson, Jeffrey Wasserman, Kristiana Raube
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RAND
PREFACE

This report documents findings from six case studies of the political evolution of smoking-control legislation. For the past several years, state legislatures have been considering a range of legislative initiatives designed to restrict smoking in public places. This report analyzes and evaluates the determinants of anti-smoking legislation. The study results provide lessons to states now debating smoking restrictions in public places. These lessons illuminate both how far the anti-smoking movement has progressed and how difficult it may be to obtain further smoking restrictions.

Funding for this project was provided by the Tobacco-Related Disease Research Program of the University of California, Office of the President. This report should be of particular interest to state legislators, public health and medical professionals, anti-smoking advocates, and the tobacco industry. It should also be valuable to researchers interested in the legislative process generally and the enactment of public health legislation specifically.
SUMMARY

INTRODUCTION
One of the most promising public policies designed to limit cigarette smoking, and one that has been used at all levels of government over the past decade, is legislation that restricts or prohibits smoking in public places. Yet despite the known dangers of tobacco use and environmental tobacco smoke, as well as rising opposition to smoking in public places, most states have not enacted stringent statewide anti-smoking legislation. This apparent anomaly led us to ask the following questions: If 80 to 85 percent of the public favors restrictions on smoking in public places, why is it so difficult to enact anti-smoking legislation? And what are the factors and processes responsible for translating public support for smoking restrictions into legislation?

Using a case study methodology, this project seeks to explain and evaluate the process by which tobacco-control initiatives become, or fail to become, law. We examined the political evolution of smoking-control legislation in six states: Florida, Illinois, Minnesota, New York, Texas, and Arizona.

Specifically, the study addressed the following research questions:

- What are the key determinants of state-level tobacco-control legislation?
- What interest group strategies most effectively circumscribe or facilitate state tobacco-control legislation?
- What are the political processes by which tobacco-control legislation is enacted?
- What lessons can be learned from California and other states?

METHODOLOGY
In each state, we interviewed knowledgeable observers of the smoking-control legislative/political process, including legislators, public health officials, members of anti-smoking coalitions (which typically included the state medical society, the major voluntary health organizations, and a variety of anti-smoking groups), and, where possible, tobacco industry representatives. The primary criterion for selecting study sites was variation in the stringency of state and local anti-
smoking legislation. Geographic distribution was a secondary selection criterion.

We identified a number of factors that we anticipated would have a significant influence on the prospects for, and ultimate shape of, state-level smoking-control legislation. These included: the presence of key legislators who were committed to enacting anti-smoking legislation, the formation of a cohesive anti-smoking coalition, and the extent to which a strong tradition existed for enacting public health measures.

RESULTS

As expected, we found that the ability of key legislators to support or block legislation and the existence of an organized anti-smoking coalition (staffed, in part, by professional lobbyists) are central to enacting anti-smoking legislation. Having a committed legislator working with an effective anti-smoking coalition does not guarantee the enactment of anti-smoking legislation, however, but such legislation is unlikely to be enacted absent either factor. Two other factors stand out as being important for enacting anti-smoking legislation. First, we found that an active executive branch places additional political pressure on the legislature to act, especially when the executive branch makes such legislation a policy priority. Second, we concluded that the existence of strong local ordinances is likely to create a policy environment that facilitates the enactment of statewide smoking restrictions. We did not find that the state's public health environment had a significant effect in shaping smoking-control legislation.

We also examined the roles played by specific organizations in the legislative/political process. We found that most state health departments and the executive branch played supportive but relatively minor roles. Moreover, state public health associations played minimal roles in the legislative process, except in Illinois. The involvement of the major voluntary health associations and the state medical societies varied across the study states, but these organizations were usually active supporters rather than leaders.

Although most tobacco industry representatives declined to be interviewed for this study, we found that the tactics and strategies used by the tobacco industry were consistent across the study states. By the late 1980s, the industry relied, for the most part, on behind-the-scenes maneuvering and was less inclined to debate anti-smoking legislation publicly. The industry also formed unusual coalitions with labor and civil liberties groups to press for provisions preventing em-
ployment discrimination against those privately using a lawful product (tobacco).

PUBLIC POLICY IMPLICATIONS

Public Opinion and Policy Change

To a certain extent, the enactment of anti-smoking legislation (both at the state and local levels) represents a policy shift during the past decade. When asked what had changed over the years to facilitate the enactment of anti-smoking legislation, most people we interviewed said public attitudes. But as our results demonstrate, the public’s broad anti-smoking sentiment is hardly a guarantee that anti-smoking legislation will be enacted.

Lacking a sufficiently committed legislator or a cohesive anti-smoking coalition, strong anti-smoking legislation is unlikely to be enacted. Whether each of the factors identified as important for influencing legislative outcomes is necessary for enacting strong anti-smoking legislation is a question we cannot answer from our study. Nor can we state with certainty which combination of factors is likely to succeed in any given state. Nonetheless, our results suggest that the active involvement of the state’s executive branch and the existence of numerous strong local ordinances, along with a committed legislator and a well-organized anti-smoking coalition, are needed to facilitate legislative action.

In view of the importance of anti-smoking coalitions as legislative policy entrepreneurs, it is instructive to consider how and why some coalitions succeed and others fail. First, to be effective in countering the financial and political strength of the tobacco industry requires relentless devotion to anti-smoking legislation from both a full-time staff and a professional lobbyist. Second, anti-smoking coalitions must be broad-based. Third, coalitions must establish close working relationships with key legislative sponsors to develop appropriate policy alternatives and to coordinate legislative strategy. Finally, coalitions should mobilize public support for smoking restrictions through effective media and grass-roots campaigns.

In addition to the importance of having a cohesive coalition, another important component of the legislative debate and outcome is how the issue of smoking restrictions is framed. In all states, the tobacco industry has attempted to shift the nature of the debate from the credibility of the scientific evidence to personal freedoms and has lobbied extensively for the inclusion of nondiscrimination clauses in smoking-control legislation. To regain the initiative, anti-smoking advocates
will need to shift legislative emphasis to a public debate over smoking's health hazards. Framing the issue in public health terms will not necessarily lead to strong anti-smoking legislation, but allowing the tobacco industry to frame the debate as one of personal freedoms certainly makes it very difficult to obtain such outcomes.

**Tobacco and Other Public Health Legislation**

Our results indicate that the relationship between tobacco-control legislation and other public health legislation appears to be less important than we initially thought. Perhaps because of the tobacco industry's lobbying clout, tobacco legislation tends to be considered on a separate legislative track. Attempts to enact public health legislation against politically and financially powerful industries must therefore be seen as long-term battles, with limited short-term expectations, for which long-term strategies are needed.

**Pursuing a Strategy to Enact Local Ordinances**

Although strong statewide legislation is likely to remain a central strategic goal for anti-smoking advocates, the difficulty of enacting such legislation suggests that anti-smoking advocates should consider devoting more resources to enacting local ordinances. A complementary local strategy has the potential for imposing smoking restrictions that might be even more stringent than corresponding statewide legislation.

**Leadership by Medical and Public Health Organizations**

In general, we anticipated considerably more leadership than we observed from public health associations, state medical societies, and voluntary health associations. We were surprised that these groups were sometimes marginal participants and rarely asserted leadership in coalitions' legislative efforts. Although we recognize that these groups have other significant legislative and organizational interests, the health effects of tobacco smoke are central to each of their stated missions. By itself, leadership by medical and public health groups may not ensure the enactment of strong anti-smoking legislation. But exercising such leadership sends an unmistakable message that public health concerns must be addressed by state legislatures.
Lessons for California

Perhaps the most important lesson learned during the course of the study is that stringent statewide smoking-control legislation can be enacted in California and in the vast majority of the states. California public opinion overwhelmingly favors additional restrictions on smoking in public places. As seen most clearly in the New York case study, states can enact strong anti-smoking legislation, despite formidable tobacco industry opposition. Finally, the fact that a substantial proportion of the California population is already covered by local smoking ordinances suggests an environment where additional restrictions are unlikely to be seen as arbitrary or cumbersome.
ACKNOWLEDGMENTS

We received valuable support throughout this project from Frank Capell, and we appreciate the support provided by the Tobacco-Related Disease Research Program of the University of California. We also appreciate the thoughtful reviews of an earlier draft by RAND colleagues Gerald Kominski and Elizabeth Rolph. In addition, we are grateful for the time spent by the various people we interviewed for this study, several of whom graciously consented to provide technical reviews of our state-specific case studies. Melinda Phelps provided excellent support in preparing the manuscript. Finally, Geraldine Dallek, a former RAND colleague, was instrumental in developing this project.
CONTENTS

PREFACE ......................................................... iii
SUMMARY ......................................................... v
ACKNOWLEDGMENTS ............................................. xi
TABLES .......................................................... xv

Section
1. INTRODUCTION ............................................. 1

2. CONCEPTUAL FRAMEWORK AND CASE STUDY
   METHODOLOGY ............................................... 3
   Conceptual Framework ........................................ 3
   Case Study Methodology ....................................... 6

3. RESULTS .................................................. 14
   Introduction .................................................. 14
   Overview of the Legislative Debates ....................... 15
   Critical Determinants of Smoking-Control
     Legislation .................................................. 19
   The Roles Played by Key Organizations .................. 27

4. DISCUSSION ............................................... 35
   Public Opinion and Policy Change ......................... 35
   How and Why Strong Anti-Smoking Legislation Is
     Enacted ...................................................... 36
   Public Policy Implications .................................. 40

Appendix
A. NEW YORK CASE STUDY ..................................... 45
B. MINNESOTA CASE STUDY ..................................... 57
C. FLORIDA CASE STUDY ........................................ 66
D. ILLINOIS CASE STUDY ....................................... 75
E. ARIZONA CASE STUDY ....................................... 85
F. TEXAS CASE STUDY .......................................... 94
G. HISTORICAL BACKGROUND OF TOBACCO
   LEGISLATION .................................................. 101
H. SMOKING LEGISLATION STUDY
   INTERVIEW GUIDE ........................................... 105
I. LETTER TO INTERVIEWEES ................................... 107

BIBLIOGRAPHY ................................................... 109
TABLES

1. Comparison of State Anti-Smoking Laws ............... 10
2. Comparison of Areas Restricted by State Anti-Smoking Laws .................................................. 11
3. Factors Influencing Legislative Outcome ............. 15
1. INTRODUCTION

Public attitudes toward smoking have undergone major changes during the past three decades. Smoking prevalence rates have declined significantly, nonsmokers have become increasingly unwilling to tolerate exposure to environmental tobacco smoke (ETS), and a large majority of Americans support restrictions on smoking in public places. Cigarette smoking is now largely viewed as harmful and anathema to many Americans—far from the glamour and style it conveyed in the 1950s. The primary reason for these changes in attitude is the accumulation of research demonstrating the health hazards of smoking.

One of the most promising public policies designed to limit cigarette smoking, and one that has been used at all levels of government over the past decade, is legislation that restricts or prohibits smoking in public places. As of 1970, only 14 states had enacted laws that restricted smoking in public places. Today, 45 states and the District of Columbia restrict smoking in some manner. At the local level, approximately 90 communities restricted smoking in public places in 1985 (CDC, 1989). By 1990, over 480 counties or cities in 34 states had enacted anti-smoking ordinances, some of which are more stringent than the corresponding state laws (Tobacco-Free America, 1990).

Yet despite the known dangers of tobacco use and ETS, as well as rising opposition to smoking in public places, only a few states have enacted comprehensive clean indoor air laws that restrict smoking in a wide range of public places (Tobacco-Free America, 1990). This apparent anomaly led us to ask the following questions. If 80–85 percent of the public favors restrictions on smoking in public places, why is it so difficult to enact anti-smoking legislation? And what are the factors and processes responsible for translating public support for smoking restrictions into legislation?

To date, there has been no attempt to address these questions through a multisite study of state-level tobacco-control legislation. We undertook such a study both to identify the main determinants of

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1Recent studies indicate that legislation restricting smoking in public places has a statistically significant negative effect on cigarette smoking, after controlling for other factors that influence cigarette consumption (such as socioeconomic characteristics and cigarette excise taxes) (Wasserman et al., 1991).

smoking-control legislation and to generate insight into the political processes that are chiefly responsible for shaping legislative outcomes.

Using a case study methodology, this project seeks to explain and evaluate the process by which tobacco-control initiatives become law. We examined the political evolution of tobacco-control initiatives in six states: New York, Minnesota, Florida, Illinois, Arizona, and Texas. Through these case studies, we analyzed the influence of a number of potential determinants of legislative outcomes, including the public health environment, political leadership, legislative strategies pursued by tobacco-control advocates and the tobacco lobby, and the state's demographic profile.

During the course of our study, we addressed four basic research questions:

- What are the key determinants of state-level tobacco-control legislation?
- What interest group strategies most effectively circumscribe or facilitate state tobacco-control legislation?
- What are the political processes by which tobacco-control legislation is enacted?
- What lessons can be learned for California and other states?

We also addressed a number of more specific research questions, including:

- How effective has the tobacco industry been in shaping state tobacco-control laws?
- How has the nature of tobacco-control legislation changed since the early 1970s?
- What lessons from attempts to enact tobacco-control legislation can be applied to other public health legislation, such as alcohol-beverage-control laws?

The remainder of this report is organized as follows. First, we discuss the study's conceptual framework and methodology. Second, we present the results of our study. Third, we discuss the implications of our results for California and other states interested in enacting additional smoking-control legislation. Finally, we report our state case studies in Appendixes A through F, and we provide a historical overview of tobacco-control legislation in Appendix G.
2. CONCEPTUAL FRAMEWORK AND CASE STUDY METHODOLOGY

CONCEPTUAL FRAMEWORK

Our conceptual approach is based on the notion that legislation in general, and anti-smoking legislation in particular, results from the interactions of various groups representing special interests (the tobacco lobby and anti-smoking advocates) and the public (as expressed through elected representatives). The main impetus for the development of smoking-control legislation (as well as the specific form of the legislation) is a set of environmental pressures on legislators regarding smoking behavior. These pressures include the public health environment of a state, the level of anti-smoking activity, the influence of the tobacco industry and other business interests, and changing societal norms as measured through public opinion polls and involvement in anti-smoking activity.

Many scholars, from economists to political scientists to organizational theorists, have attempted to explain why the government enacts legislation to regulate the behavior of individuals, industries, and institutions. Much of this work has focused on economic regulation. However, many of the analytical insights gained through the study of economic regulation are applicable to public health and other types of legislation. Moreover, it is often difficult to distinguish or categorize particular types of legislation. For example, environmental legislation can be characterized as either economic or public health legislation, or both.

Early work by political scientists posited that legislation reflected public demand to correct inefficient or inequitable market practices. According to this view, industries are regulated for the protection and benefit of the public at large. However, this theory was dismissed by many economists, who viewed it as inconsistent with microeconomic theory (Posner, 1974) and as simply “normative wishings rather than real world phenomena” (Kalt and Zupan, 1984).

A competing explanation of legislative and regulatory behavior—the “capture” theory of regulation—holds that regulations are supplied in response to the demands of various interest groups. The legislative analogue of the regulatory capture theory, as formulated by economists, is that legislation serves the private interests of politically favored groups. In his seminal work, Stigler (1971) posits that
the aim of politicians is to maximize their votes, wealth, or power. Therefore, politicians cater to powerful organized interest groups that will benefit from a particular piece of legislation rather than to consumers (or constituents). This theory, subsequently supported by public choice theorists, implicitly assumes that altruistic, public interest goals are insignificant factors in the political process. It also assumes that legislative outcomes result from bargains reached between legislators and interest groups.

As applied to tobacco-control legislation, the interest group theory predicts that tobacco producers and cigarette manufacturers would attempt to influence key legislators through their broad economic power as well as through political campaign contributions. In return, the legislators would vote for laws that support tobacco industry interests. Although this theory can in part explain the outcome of anti-smoking legislation in those states in which such legislation has failed to be enacted (such as the tobacco-producing state of North Carolina), the theory cannot explain how restrictive legislation was passed in states such as New York and Minnesota.

In response to such anomalies, recent debate in the literature questions whether some version of a public interest theory might be needed to broaden the essentially economic theory of politics. Kalt and Zupan (1984) write that “approaches that confine themselves to a view of political actors as narrowly ego-centric maximizers explain and predict legislative outcomes poorly.”

Political scientists, such as Wilson (1980), are also dissatisfied with the capture theory because it fails to explain those instances when legislation does not necessarily serve producers at the expense of consumers. He offers another explanation of the political process by classifying policy proposals in terms of the perceived distribution of their costs and benefits. For example, in majoritarian politics, costs and benefits are widely distributed. Because all parts of society are expected to pay and all are expected to gain, there are no real interest groups in majoritarian politics. In interest group politics, costs and benefits are narrowly concentrated. Consequently, each side has a strong incentive to organize. Usually, the final legislation includes something to please everyone. In client politics, benefits are concentrated and costs are widely distributed. As a result, small groups that will benefit have strong incentives to organize and lobby. However, since costs per capita are low, there is little incentive for the opposition to organize.

Finally, in entrepreneurial politics, there are general benefits across society, but the costs are relatively concentrated. In this case, the in-
centive to organize is strong for the opponents but weak for the beneficiaries. The benefits of anti-smoking laws—though large in terms of health—are diffuse, but the costs are largely imposed on the tobacco industry. Therefore, skilled entrepreneurs are needed to work on behalf of the legislation’s beneficiaries. According to this view, the prospects for passing legislation that restricts smoking in public places may depend upon the ability of “entrepreneurs” (that is, anti-smoking advocates) to frame the issue in a manner that minimizes the probability of legislator opposition.

Closely resembling Wilson’s entrepreneurial model is Kingdon’s (1984) model of the federal legislative process. Kingdon’s model focuses on agenda-setting (dominated by the executive branch) and the development of policy alternatives that can be converted into legislation at the appropriate opportunity. According to Kingdon, legislation results from three process streams: problem identification, the development of politically acceptable policy alternatives, and windows in the political process (such as a change in administrations). Because so few potential problems become the subject of legislation, the likelihood of legislation is enhanced if it is considered to be an important policy problem. Once a problem is identified, there needs to be a series of politically acceptable policy solutions that can form the basis of legislation. Windows in the political process, such as a shift in national mood, present opportunities for linking problems, policy proposals, and politics. When these streams come together, legislation can be enacted. In this model, the key to enacting anti-smoking legislation is understanding how smoking is identified as a policy problem and placed on the political/legislative agenda.

An alternative theory for explaining differences between state laws regulating smoking in public places is offered by Elazar (1972), who contrasts states and their laws in terms of differing needs and interests. He believes that each state has its own political culture, differentiating it from other states in terms of habits, perspectives, and attitudes. Essentially, each state has its own personality, which in part explains how and why it reacts differently than other states to similar situations. For example, Texas has an apparent aversion to government intervention, which may explain why it has not passed any significant statewide legislation restricting smoking. Classifying each state according to its political culture is a difficult and controversial

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1Kingdon’s study is of the federal legislative process and may not be directly applicable to state decisionmaking, although certain similarities are obvious. Kingdon’s premises on agenda-setting assume executive branch primacy, whereas in most of our states, the policy agenda is set by the legislature.
proposition, and as our results suggest, reliance on an intuitive understanding of a state's political culture would be a misleading predictor of legislative outcomes.

CASE STUDY METHODOLOGY

To the best of our knowledge, this is the first multistate study that attempts to examine the process of enacting public health legislation. We used a case study approach to explain how and why tobacco-control initiatives are enacted (or not enacted) into law in the six states.

In each state, we interviewed knowledgeable observers of the smoking-control legislative/political process, including legislators, public health officials, members of anti-smoking coalitions (which typically include the state medical society, the major voluntary health organizations, and a variety of anti-smoking groups), and, where possible, tobacco industry representatives. The sites were selected to represent a balance in both geographic diversity and legislative stringency. We were also interested in selecting states that were at different points in the legislative process; some states passed tobacco-control legislation several years ago, and others are currently debating similar legislation. This enabled us to compare how strategies change and how the political process develops over time.

Potential Factors Influencing the Legislative Process

At the outset of our study, we identified a number of factors that we anticipated would have a significant influence on the prospects for, and ultimate shape of, state-level smoking-control legislation. Although the factors selected most closely resemble those predicted to be significant by either Wilson's entrepreneurial model or Kingdon's model of the federal legislative process, these factors would also be identified through an economic or political culture model. Thus, under each of the current theories of the legislative process discussed above, the following are the primary factors likely to be important in assessing the outcome of anti-smoking legislation.

- **Key legislator**—This refers to the extent that impending smoking-control legislation is supported by a legislator who is strongly committed to its passage. We expect that a key legislator is able to set the political agenda and to work with other advocates of smoking restrictions in identifying strategies to enact legislation.

- **Anti-smoking coalition**—Typically, a coalition of health-related groups and organizations is formed in a state with the purpose of
securing smoking-control legislation. However, the strength of the coalition's organization and cohesiveness varies considerably from state to state. We identified those groups likely to be candidates for membership in anti-smoking coalitions.

- **Medical organization**—This pertains to the level of involvement of the state's medical society, as well as other medical and public health organizations, in smoking-control legislative activities.

- **Business community**—This factor refers to the extent that businesses and industries other than the tobacco industry oppose smoking-control legislation and enter into political coalitions with tobacco interests.

- **Executive branch**—This factor takes into account the degree of the state's executive branch involvement in supporting smoking-control legislation. In general, the state department of health takes the lead in this area, although other state agencies and the governor's office may also be active participants.

- **Public health environment**—This reflects a state's general willingness to support public health legislation and activities. For example, has the state enacted motorcycle helmet, mandatory seatbelt, or stringent environmental laws? We use this factor as a proxy for a state's political culture, assuming that a state with other public health legislation would be more likely to enact smoking restrictions than a state lacking other public health legislation.

- **Tobacco industry**—We assume that the tobacco industry's activity is constant across the states in its determination to defeat smoking-control legislation in a particular state. That is, we assume that the tobacco lobby invests financial and political resources proportionate to the likelihood of enacting anti-smoking legislation in a state.

- **Media**—This factor refers to the extent that the media are used by either side to generate support for its cause. We were interested both in whether the media play a role in generating support for either cause, by, for example, printing editorials favoring or opposing additional smoking-control legislation and covering related activities, and in how each side generates such media attention.

- **Public opinion**—We anticipated that public opinion favoring smoking restrictions, such as state public opinion polls and constituent sentiment, would facilitate the enactment of smoking-control legislation.
• **Local legislation**—This refers to the degree that local ordinances governing smoking in public places have been passed throughout the state.

**Site Selection**

The primary criterion for selecting study sites was variation in the stringency of state and local anti-smoking legislation. Legislative stringency is a measure of the legislation's scope (that is, where smoking restrictions are imposed and the extent of the restrictions) and constraints (such as preemption or smokers' rights provisions). The attributes of strong legislation, as defined below, include outright prohibition in several public places, smoking restrictions at private worksites, a burden on the smoker to have a smoking area provided, and the absence of both preemption and smokers' rights provisions. Weak legislation is characterized by the presence of preemption or smokers' rights provisions. Our characterization of legislative stringency is based on our analysis of certain legislative provisions (described below), discussions with several persons knowledgeable about anti-smoking legislative trends, and legislative summaries provided by Tobacco-Free America (1990).

Geographic distribution was a secondary selection criterion; we selected one state each from the Northeast, the Southeast, the South, the West, and two from the Midwest. We also chose states that were different demographically. For example, Arizona has a relatively small population, Florida has a large number of older residents, New York has a large minority population, and Texas has a large percentage of its population living below the poverty level. In addition, we chose states that differed across various health status measures. Minnesota is the healthiest state in the nation according to the Northwestern National Life Insurance ratings, whereas Texas and Florida both have a high prevalence of men who smoke. However, we excluded tobacco-growing states because the economic base and

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2Arizona's population is about 3.5 million; New York's is almost 18 million.

3In Florida, almost 18 percent of the population is 65 and over; in Illinois that number is only 12 percent.

4In New York, over 9 percent of the population is black; in Minnesota, less than 0.2 percent of the population is black.

5Almost 15 percent of Texans live below the poverty level; only 9.5 percent of Minnesotans live in poverty.

6This measure rates a state's health based on a combination of factors, including disability, disease, mortality rates, lifestyle characteristics, and access to health care.

7In Texas, 33.6 percent of men smoke; in Florida, 33.1 percent smoke.
history of tobacco-growing states were so closely tied to smoking that it would be difficult to "control" for those factors when making comparisons with other states.

The states selected also varied in the mix of state and local anti-smoking laws. Our sample is thus composed of two states that have enacted strong statewide anti-smoking legislation (Minnesota, with weak local ordinances, and New York, with strong local ordinances), two states that have enacted weak anti-smoking legislation but have some strong local ordinances (Florida and Illinois), and two states where significant anti-smoking legislation has not been enacted or has been defeated but that also have some strong local ordinances (Arizona and Texas).

Table 1 compares state smoking-control laws across several important dimensions:

- **Preemption**—This refers to a provision in state smoking-control legislation that allows state law to preempt (i.e., to take precedence over) stricter local ordinances. If statewide legislation preempts local legislation, the overall effect of the state legislation may be to weaken the level of smoking restrictions, particularly in a state with a large number of relatively stringent local ordinances.

- **Outright prohibition**—This is simply an indicator of whether the state law prohibits smoking under any circumstances in one or more public places.

- **Smokers’ rights**—Smokers’ rights provisions of smoking-control legislation generally guarantee that smokers have certain rights while pursuing the legal activity of smoking. As explained below, this represents several personal freedoms arguments now being raised by the tobacco industry, including nondiscrimination in employment against smokers.

- **Private worksite**—This is an indicator of the scope of the legislation, whether it restricts smoking in private worksites.

- **Burden**—This refers to which party, the smoker or the non-smoker, has the burden of requesting that a proprietor provide a smoking or nonsmoking area. Where the legislation restricts smoking generally, the burden is on the smoker to show that the activity is allowed in certain designated areas.

- **Enforcement**—This includes the range of sanctions for violations of the law and where enforcement responsibility lies.
Table 1
Comparison of State Anti-Smoking Laws

<table>
<thead>
<tr>
<th>State</th>
<th>Preemption</th>
<th>Outright Prohibition</th>
<th>Smokers' Rights</th>
<th>Private Workplace</th>
<th>Burden</th>
<th>Enforcement</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Smoker</td>
<td>Local County Board of Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Civil penalty</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>≤ $1000 state</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>≤ $500 local</td>
</tr>
<tr>
<td>Minnesota</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Smoker</td>
<td>State Commissioner of Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Petty misdemeanor</td>
</tr>
<tr>
<td>Florida</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Non-smoker</td>
<td>Department of Health periodic inspections</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1st offense = $100</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2nd offense = $500</td>
</tr>
<tr>
<td>Illinois</td>
<td>Yes&lt;sup&gt;a&lt;/sup&gt;</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Smoker</td>
<td>Petty offense ($500)</td>
</tr>
<tr>
<td>Arizona</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Non-smoker</td>
<td>Petty offense</td>
</tr>
<tr>
<td>Texas</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Non-smoker</td>
<td>&lt; $200</td>
</tr>
</tbody>
</table>

<sup>a</sup>Grandfathered laws in place before October 1, 1989.

From our analyses of the study states’ anti-smoking legislative and regulatory structures, we have determined that New York and Minnesota have strong anti-smoking provisions. Because of New York’s extensive local ordinances, we have ranked it first among the study states. Both Florida and Illinois have statewide legislation preempting more stringent local ordinances, thus we categorize these states as having weak anti-smoking legislation. Between the two states, Florida is ranked higher by virtue of Illinois’ ambiguous smokers’ rights provision. Neither Arizona nor Texas has enacted even modest statewide smoking restrictions, but Arizona is ranked higher on the basis of its stronger local ordinances.

In Table 2, we describe the areas where smoking is restricted across the study states. Although this table depicts the range of activities covered by anti-smoking legislation, in the absence of additional information on enforcement, burden, and the scope of coverage, it is difficult to differentiate the laws based solely on a list of areas covered. Taken together, Tables 1 and 2 suggest that several different
Table 2
Comparison of Areas Restricted by State Anti-Smoking Laws

<table>
<thead>
<tr>
<th>Area</th>
<th>NY</th>
<th>MN</th>
<th>FL</th>
<th>IL</th>
<th>AZ</th>
<th>TX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arts/cultural facilities</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Child care centers</td>
<td></td>
<td>P</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government buildings</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Gymnasiums/arenas</td>
<td>P</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health facilities</td>
<td>X</td>
<td>B</td>
<td>B</td>
<td>X</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Intrastate commerce</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Jury/courtrooms transit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meetings</td>
<td>X</td>
<td>B</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public transit</td>
<td>B</td>
<td>X</td>
<td>X</td>
<td>A</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Restrooms</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Retail/grocery stores</td>
<td>B</td>
<td>X</td>
<td>A</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schools</td>
<td>B</td>
<td>A</td>
<td>B</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Public places</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Restaurants</td>
<td>A</td>
<td>X</td>
<td>A</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private sector workplaces</td>
<td>X</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

P = Prohibited at all times (no exceptions).
B = Prohibited at all times in some places and prohibited, except in designated areas, in other places.
X = Prohibited, except in designated areas (no exceptions).
A = Prohibited, except in designated areas (not all-inclusive; allows exceptions).

dimensions actually determine the strength of anti-smoking legislation.\textsuperscript{8}

Pre-Site Visit Preparation

Before visiting each state, we undertook an extensive review of the local and statewide anti-smoking legislation enacted during the past 15 years. With the help of the RAND library staff, we searched MEDLINE, newspaper, magazine, and law indexes for any articles related to smoking legislation in the six states. This provided a context in which to evaluate the current legislation, to investigate political and interest group activity, and to examine public opinion and the public health environment. We also reviewed available data on population demographics, such as the Census and Current Population Survey.

\textsuperscript{8}A related question, beyond the scope of this project, is to develop more precise measures of regulatory and legislative stringency. Although 46 states have enacted some form of anti-smoking legislation, it is difficult to compare the stringency of smoking restrictions across states without better measures than those currently available.
Following our initial overview of the publicly available information for each site, we developed a preliminary list of interviewees by contacting individuals in what were likely to be key state agencies or private organizations (e.g., the state health department, the major voluntary health associations, and the state medical society). During these initial contacts, we arranged appointments and inquired about additional contacts, including legislators who were principally responsible for introducing (or blocking) important smoking-control bills. We continued this process until we had arranged appointments with representatives from all key agencies and organizations in each study site and concluded that we had conducted a thorough search for additional contacts.

Before visiting each site, we developed a standard interview guide (attached as Appendix H), which served to organize note-taking, ensure that all topics were covered, and provide consistency across interview sites. Each interview guide contained a set of core questions and topics for discussion, as indicated in a letter sent to each prospective interviewee (attached as Appendix I). The interview guide also included specific questions to elicit the role the interviewee (or the group represented) played in the legislative process. Additionally, each guide contained a set of site-specific questions that we developed after reviewing the articles and papers that pertained both to the state’s smoking-control legislation and to smoking-related issues that appeared to be particularly salient.

Site Visits

Target interviewees for each state included senior officials in the governor’s office, the state health department, and the legislature. We also arranged to meet with leaders of state medical societies, anti-smoking advocacy groups, and voluntary health organizations (such as the American Cancer Society, the American Lung Association, and the American Heart Association). Finally, we attempted to meet with officials and attorneys for the tobacco industry.

During each site visit, which typically lasted for one week, the state legislature was in session. This, together with an enormous amount of cooperation on the part of state health officials and anti-smoking coalition members, enabled us to meet with virtually all interviewees that we targeted. The one exception was our inability to meet with any tobacco industry representatives except those in Illinois. Our interviews ranged considerably in length—from less than a half-hour with busy legislators or interviewees who were unable to provide much information about the legislative process to more than two
hours with individuals who had immersed themselves in the issue and consequently had a substantial amount of information to impart. On average, however, the interviews lasted just over an hour.

**State Case Study Reports**

We synthesized the information collected during the site visits in a series of state-specific analyses. We then submitted a draft of each analysis to a key contact in each state to review it for technical accuracy. As necessary, telephone conversations were later held with the reviewer to clarify specific comments. As noted above, the state-specific case study reports are attached as Appendixes A–F.

**Study Limitations**

Our study has two main limitations. The first limitation, which is common to all case studies, centers on the degree to which our sample of states is representative of all states. Although we chose study sites that represent a geographic and legislative cross-section of anti-smoking activity, our small sample size may limit the generalizability of our results.

The second limitation is that representatives of the tobacco industry were unwilling to meet with us in five of the six states we visited, despite our concerted efforts. As a result, our description of the tobacco industry's role in the six states is necessarily based on only a handful of interviews with tobacco industry representatives coupled with substantial information obtained from legislators, anti-smoking advocates, and others generally knowledgeable about the tobacco industry's role in opposing anti-smoking legislation. It is possible, however, that we did not accurately represent the industry's views or strategies.

Even with these limitations, we remain confident about our results and analysis. The number and range of interviews we completed revealed a high level of consistency both across and within states.
3. RESULTS

INTRODUCTION

The primary objective of this study was to examine the factors and political processes that influence the enactment of statewide anti-smoking legislation. Table 3 summarizes the influence of each factor described in Sec. 2 on a state's legislative outcome.

Using the results of our site visits, we assessed each factor’s importance in explaining the state’s legislative outcome on a three-point scale of strong, weak, or absent. By strong, we mean that the factor was suggested by a substantial majority of interviewees as being important in describing the legislative outcome. Often, the factor was identified by the interviewee without specific reference from the interviewer. By weak, we mean that the factor was mentioned only sporadically during our interviews, usually in response to direct questioning by the interviewer, and only a few interviewees ascribed significance to it. By absent, we mean that few, if any, interviewees raised the topic or considered it to be important when it was suggested by the interviewer.

Despite variation in the degree to which each factor was judged important across the study states, several points stand out from Table 3. As expected, the primary determinants of legislative outcomes appear to be key legislators and effective anti-smoking coalitions. The existence of an organized anti-smoking coalition (staffed, in part, by professional lobbyists) and the ability of key legislators to support or block legislation are central to enacting anti-smoking legislation. Taken together, these are the primary necessary, but not sufficient, factors operating to determine legislative outcomes. Having a committed legislator working with an effective anti-smoking coalition does not guarantee the enactment of anti-smoking legislation, but such legislation is unlikely to be enacted absent either factor, as we found in Texas and Arizona.

Also as expected, the tobacco industry is strongly represented in each state (except for the 1975 Minnesota legislation), thus confirming our assumption that tobacco industry interests are constant across the states. Contrary to our initial views, however, it seems clear that the public health environment, medical/public health organizations, and, except for New York, a state’s executive branch are less important in explaining legislative outcomes. The existence and strength of local
Table 3
Factors Influencing Legislative Outcome

<table>
<thead>
<tr>
<th>Factor</th>
<th>NY</th>
<th>MN</th>
<th>FL</th>
<th>IL</th>
<th>AZ</th>
<th>TX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strength of legislation</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Key legislator</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Anti-smoking coalition</td>
<td>■</td>
<td>□</td>
<td>■</td>
<td>□</td>
<td>■/□</td>
<td>□</td>
</tr>
<tr>
<td>Medical organization</td>
<td>□</td>
<td>0</td>
<td>□</td>
<td>□</td>
<td>0</td>
<td>■</td>
</tr>
<tr>
<td>Business community</td>
<td>□</td>
<td>0</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Executive branch</td>
<td>■</td>
<td>□</td>
<td>0</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Public health environment</td>
<td>□</td>
<td>■</td>
<td>0</td>
<td>□</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tobacco industry</td>
<td>■</td>
<td>0</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>Media</td>
<td>□</td>
<td>□</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Public opinion</td>
<td>■</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Local legislation</td>
<td>■</td>
<td>0</td>
<td>□</td>
<td>□</td>
<td>■</td>
<td>■</td>
</tr>
</tbody>
</table>

■ = Strong
□ = Weak
0 = Absent

Ordinances appear to be important indicators facilitating the enactment of statewide legislation.

OVERVIEW OF THE LEGISLATIVE DEBATES

Before considering the critical determinants of anti-smoking legislation in greater detail, it is useful to provide the context of the legislative debates in which the determinants can best be understood. Through these debates, we get a clearer understanding of the political evolution of smoking-control legislation. Naturally, the debates varied across the states, but certain overall patterns emerged that help to explain legislative outcomes.

The predominant characteristic of the policy debate over legislating smoking restrictions is the tension between the public health arguments (the harm from smoking) raised by proponents of smoking restrictions and the personal freedoms arguments (the right to consume a legal product) raised by the tobacco industry. Although the legislative outcome in any state is not directly a function of which side controls the debate, it appears that anti-smoking forces fare better when public health issues dominate and that the tobacco industry benefits when personal freedoms arguments are predominant. In our six states, legislative outcomes favored anti-smoking advocates during the time that public health dominated the debate. Once the debate shifted to personal freedoms, anti-smoking legislation stalled.
Most of the legislative debates from the late 1970s through the mid to late 1980s centered on the sufficiency of the scientific evidence to justify legislative intervention. The tobacco industry strongly contested the validity of the scientific evidence, but the debates were dominated by public health advocates, and legislators began dismissing tobacco industry claims. Many observers suggest that the accumulation of scientific evidence about the health hazards of smoking undermined industry claims that there is no causal relationship between smoking and disease. Almost all observers credit the Surgeon General’s reports, especially the recent reports detailing the harm to nonsmokers from environmental tobacco smoke (ETS), for having ended the scientific debate about smoking’s potential harm to smokers and nonsmokers alike. Even though several anti-smoking legislators admitted that the evidence on harm from ETS was not yet conclusive, they were nevertheless able to use ETS to blunt tobacco industry arguments against governmental interference and in favor of smokers’ rights.

By the time anti-smoking legislation was enacted in New York and Illinois, and considered in Florida, for instance, the debate on the epidemiological aspects of smoking limitations had receded into the background. Very few legislators were interested in pursuing tobacco industry attempts to discount the scientific evidence. It appears as though after years of considering tobacco-control legislation, the legislators had become inured to further debate on the merits. More to the point, almost everyone in these states agreed that the tobacco industry had effectively “lost” the scientific debate, in part resulting from the effective use of ETS by anti-smoking coalitions.

Beginning in the mid to late 1980s, however, a secular shift appeared in the nature of the debate—away from considering scientific evidence and toward debates over personal freedoms—largely resulting from a revised tobacco industry strategy to emphasize personal freedoms issues. Having lost on the scientific merits, the tobacco lobby shifted its opposition to smoking restrictions to a broadly conceived personal freedoms argument involving three interconnected ap-

1Typical of the legislative response to the scientific evidence is the following: “After 25 years of research, the Surgeon General has concluded, and it is conclusive, that the health-related aspects of smoking kill over 300,000 people a year in the United States. More people die from the effects of smoking in the United States than traffic accidents, alcohol-related, drug-related, homicides . . . combined.” Remarks of Senator Bruno, New York State Senate Debates, 5 July 1989, pp. 3790-3791. In both Florida and Illinois, tobacco industry lobbyists argued that environmental harm emanates from “sick buildings,” not cigarette smoke, a claim that received little credence among legislators.
proaches: first, governmental interference—that smoking restrictions should be determined by private economic arrangements, not by governmental fiat;\textsuperscript{2} second, smokers’ rights—that smokers have certain rights in pursuing a legal activity; and third, nondiscrimination—that smokers cannot be discriminated against by employers for their smoking behavior, particularly for smoking during nonworking hours. By the late 1980s and into the 1990s, the debate in each of our study states began to be dominated by personal freedoms issues.

Personal freedoms arguments appeal to an unusual coalition of civil liberties advocates, libertarians, and conservatives who generally support business interests. This strategy appears to be an attempt to frame the issue in a way that makes it particularly difficult for civil liberties advocates and minority legislators to oppose. At the same time, the smokers’ rights and nondiscrimination arguments are particularly anathema to anti-smoking advocates who fear that in practice these provisions could undermine broader smoking controls.

So far, these personal freedoms arguments appear to have had mixed results for the tobacco industry, but they are clearly more effective than continued reliance on contesting the scientific evidence would likely have been. Recent success in Arizona, Florida, and Illinois\textsuperscript{3} (as well as in some nonstudy states) suggests that the personal freedoms arguments are beginning to resonate among state legislators, despite public opinion favoring smoking restrictions and the health hazards associated with secondhand smoke.\textsuperscript{4}

The primary benefit to the tobacco industry from the personal freedoms arguments appears to be an ability to dominate legislative deliberations in states where the anti-smoking coalitions are just beginning efforts to influence legislation. This makes it harder for anti-smoking advocates to focus the legislative debate on scientific or public health concerns. In Texas and Arizona, for instance, the extensive scientific debate seen earlier in other states is largely absent, and the focus is almost entirely on personal freedoms arguments. Several legislators in these states complained that the anti-smoking advocates

\textsuperscript{2}Whenever possible, the tobacco industry attempts to exploit any existing antipathy toward governmental interference in matters related to private behavior.

\textsuperscript{3}In Florida, tobacco interests were able to amend a nondiscrimination provision to anti-smoking legislation at the last moment, thereby effectively killing the bill. After the conclusion of our interviews, Illinois enacted legislation prohibiting an employer from discrimination based on the lawful use of a product off the premises. A coalition of tobacco, labor, and civil liberties interests prevailed over the objections of other businesses.

\textsuperscript{4}As noted, the issue of ETS has been used successfully to deflect the tobacco industry’s personal freedoms arguments in some states, including New York.
have not done enough to demonstrate the scientific evidence to the legislature and to the general public. These legislators also suggested that, at least in these states, the scientific evidence is perhaps not sufficiently disseminated to be persuasive on its own merits.

Accompanying the shift to personal freedoms arguments, many state legislative deliberations changed from a public debate to a private, behind-the-scenes battle between lobbyists. To a certain extent, the legislative process in many states has become a classic insider's game played by sophisticated lobbyists on both sides. In Florida, for example, legislators favoring smoking restrictions were unable to delineate tobacco industry arguments because the industry was not responding publicly to the proposed anti-smoking legislation. Instead, as in New York, the tobacco lobby relied on key legislators to attach preemption or nondiscrimination provisions at the end of the legislative session. And in Texas, tobacco lobbyists have succeeded in detaining smoking-control legislation in committee, session after session.

This ability to maneuver behind the scenes provides the tobacco industry with an additional advantage that we observed in several of our study states. Contentious legislation is often enacted in chaotic end-of-session negotiation and compromise. The legislative outcomes in New York, Florida, and Illinois were in doubt until the sessions' final moments. In this environment, the more monolithic tobacco industry has a tactical advantage because it is easier to block than to enact legislation. Thus, the tobacco industry can focus on parliamentary maneuvers designed to delay or block consideration of a bill, whereas the anti-smoking coalition is often presented with difficult tactical and strategic decisions over what provisions to accept. In both Illinois and New York, this decision concerned preemption of local legislation in return for at least some statewide coverage. In Florida, a similar decision was presented regarding acceptance of a nondiscrimination provision.

In most of the legislative debates we observed, tobacco industry supporters have also attempted to raise the costs of enforcement and the threat of an intrusive "smoking police" to defeat anti-smoking legislation. For the most part, these arguments have been treated by legis-

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Interestingly, Samuels and Glantz (1991) found that the tobacco industry's apparent penchant for remaining out of the public's eye operates at the local level as well: "For example, the Tobacco Institute's West Coast lobbyist, Ron Saldana, attended hearings on local smoking control ordinances but rarely testified publicly; when asked why, he said, 'I've learned from experience that as soon as I'm identified as a representative of the Tobacco Institute, I lose all credibility. They just sneer us away... so I try to work behind the scenes whenever I can.'"
lators as a “smokescreen.” An Illinois Department of Public Health survey of the costs and potential regulatory burden of enacting smoking restrictions effectively countered tobacco industry arguments that the Illinois legislation would be too costly to implement.

We have tentatively concluded that once enacted, statewide anti-smoking legislation is largely self-enforcing. Even states with stringent anti-smoking legislation have not developed strong enforcement mechanisms, relying instead on public acceptance of the law to ensure compliance. Thus, allegations by the tobacco industry and its allies that police would have to be employed to enforce no-smoking laws are not supported by current legislative provisions. Rather, tobacco-control legislation is likely to be successful in curtailiing smoking in public places because these restrictions generally enjoy widespread public support.

Interestingly, most of the debates appear to have been nonpartisan, although Republicans tend to oppose smoking restrictions more than Democrats. In Florida, for example, the Republican governor vetoed a bill that contained a nondiscrimination clause unacceptable to the anti-smoking coalition. And in Illinois, many downstate Democrats opposed statewide legislation as interfering with local prerogatives, although Republican Governor Thompson supported the bill.

CRITICAL DETERMINANTS OF SMOKING-CONTROL LEGISLATION

Legislative Leadership

As political science theory predicts, key legislators are crucial either in pushing anti-smoking legislation or in blocking the enactment of such legislation. Most important, key legislators are able to keep anti-smoking legislation on the legislative/political agenda despite two inherent difficulties in enacting such legislation. First, smoking-control legislation competes for legislative attention with other pending policy problems. Although the accumulation of scientific evidence identifies smoking as a problem, there is rarely a major crisis or event propelling smoking to the forefront of policy problems. Second, the politically powerful tobacco industry has an interest in burying any attempts to restrict smoking behavior. Given the historical ability of the tobacco industry to dominate the legislative process, anti-smoking legislation is unlikely to progress without the support of a committed legislator. Except for New York, key legislators were far more important than the executive branch in identifying smoking as a problem
and in setting the legislative agenda to consider anti-smoking legislation.

Thus, enacting anti-smoking legislation depends on the willingness of a legislator to pursue the legislation, perhaps for a period of many years. In New York and Illinois, for instance, one legislator in each state pursued the issue for 13 years before enactment. Additionally, Minnesota’s Clean Indoor Air Act was the direct result of a single legislator’s efforts. Our site visits confirm that without these legislators, it is unlikely that these states would have enacted strong anti-smoking legislation. In Texas and Arizona, such committed legislative support has been absent, and no statewide legislation has been enacted.

For the tobacco industry to achieve its objective of blocking the passage of smoking-control legislation, strong legislative support, particularly among legislative leaders, has been equally important. In many instances, key legislative leaders sympathetic to the tobacco industry have been able to block, or heavily amend, stronger anti-smoking legislation. Even where strong legislation was ultimately enacted, such as New York, pro-tobacco industry legislative supporters were able to delay action for several years. In Florida, strong legislation actually passed both houses of the legislature in 1991, but pro-tobacco legislators in the leadership were able first to delay the final vote and then to attach a nondiscrimination provision, effectively killing the bill.

The influence of personalities and leadership changes on legislative outcomes must also be considered. In Illinois and New York, many attribute the enactment of anti-smoking legislation to personnel and leadership shifts. In Illinois, the anti-smoking advocates shifted to a new legislative sponsor who was then able to forge compromise legislation. In New York, a change in the Senate leadership and health committee chair provided the impetus for strong legislation to pass. The previous leader and health committee chair had successfully blocked the legislation for years, but the new leader and health committee chair were elected from communities with strong local anti-smoking ordinances, making it difficult for them to agree to preempt local ordinances.

**Anti-Smoking Coalitions**

Typically, anti-smoking coalitions comprise representatives from the state medical society and public health organizations, the major voluntary health associations (the American Cancer Society, the
American Heart Association, and the American Lung Association), anti-smoking advocacy groups (such as Americans for Nonsmokers’ Rights), and, in some cases, the state department of health and other executive branch agencies. In almost every state, our interviewees credited the formation of a broad-based anti-smoking coalition, and the concomitant hiring of professional lobbyists, with effectively translating public sentiment against smoking into a viable legislative issue, regardless of the eventual legislative outcome.

Coalitions serve several basic functions that are critical in the legislative process. These functions usually include:

- Organizing disparate interest groups, with differing legislative and policy agendas, around a common political concern.
- Placing the smoking issue on the policy/political/legislative agenda.
- Organizing at the grass-roots/local level to generate constituent support.
- Mobilizing public opinion and media attention.
- Acting as a countervailing lobby to the tobacco industry.
- Disseminating scientific evidence about the health hazards of smoking.

Although we found the coalitions’ strategies, goals, organizing principles, and standard operating procedures to be quite similar across the six states studied, we also found considerable variation across coalitions in their ability to fulfill these functions effectively. All coalitions did well in placing and keeping smoking restrictions on the legislative agenda. In each state, the coalition presented the legislature with suitable policy alternatives both to stimulate and to take advantage of changes in public attitudes.

Other functions, however, were not as uniformly successful. Some coalitions, such as in New York, effectively incorporated disparate interest groups; others, such as in Florida, failed to include potential supporters, such as senior citizens’ organizations. Most coalitions effectively disseminated scientific information, but the Texas and

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6Hinz (1990) provides a valuable and thorough description of the events that culminated in New York’s Clean Indoor Air Act. As a former member of the anti-smoking coalition, Hinz stresses the role of the coalition as the dominant reason for the legislation’s passage. Our interviews, however, suggest that other factors are equally important, although we agree with his assessment of why an anti-smoking coalition is necessary for enacting anti-smoking legislation.
Arizona coalitions were criticized by legislators for their failure to do so.

Even though the importance of the coalition to the legislative outcome varied across states, arguably less in New York and greater in Illinois, we conclude that in light of the tobacco industry's strong legislative influence, it is unlikely that proposed anti-smoking legislation can be enacted absent a coalition's efforts in fulfilling these functions. Neither Illinois nor New York had enacted anti-smoking legislation absent the coalition's activities, despite persistent efforts by committed legislators. Before forming the Illinois coalition, each group relied on independent organizing efforts, which were no match for the tobacco lobby. Once the organizations combined their efforts and hired a professional lobbyist to coordinate their activities, they were able to compete with the tobacco industry. The experience in Arizona and Florida, which lack effective coalitions and have had only limited success in enacting statewide anti-smoking legislation, also supports this conclusion.\textsuperscript{7}

Coalitions often face significant internal and external problems that make it difficult to achieve the above functions. Externally, they must compete with the financially and politically powerful tobacco lobby, which has years of lobbying experience and contacts. Internally, they are a conglomerate of different groups with differing agendas and often competing interests. Unlike the tobacco industry, they are not a monolithic lobby. For example, the voluntary associations, which provide most of each coalition's resources, are generally more willing to compromise than are coalition members representing single-issue advocacy groups.\textsuperscript{8}

The primary internal difficulty is maintaining cohesiveness under the stress of competing interests while forging the tactical compromises necessary to enact legislation. In virtually every state, the coalition was split over whether to compromise on such issues as preemption and smokers' rights, or over internal personality conflicts. Anti-smoking coalitions in both Florida and Illinois split over preemption,\textsuperscript{9}

\textsuperscript{7}Although strong anti-smoking legislation was enacted in Minnesota without an organized coalition, this appears to be an anomaly. As we detail in the Minnesota case study, this occurred largely because the tobacco industry virtually ignored the legislation. It is unlikely that the tobacco industry will ignore such legislation now in any state.

\textsuperscript{8}At the same time, the voluntary associations are quite protective of their own interests. In Minnesota, for example, the voluntary associations were reluctant to share their mailing lists among coalition members for fear that doing so would reduce contributions to their own agencies. This, however, may be a rational response given the competing interests that these organizations must juggle.
with the majority in each case willing to accept a bill preempting local ordinances rather than having no statewide legislation. In New York, the coalition also split over this issue but preferred no bill to one that preempted strong local ordinances, after considerable pressure to reject a compromise was applied by the state health commissioner. And in Arizona, the coalition split over the issue of whether smoking should be regulated at the state or local level.

In each case, the split undermined the coalition’s effectiveness by fragmenting the base of support presented to the legislature and by allowing opponents to employ a divide and conquer strategy. The Arizona case study illustrates how a divided coalition can dampen legislative enthusiasm for supporting smoking restrictions. Several Arizona legislators indicated that they were reluctant to push for statewide legislation until anti-smoking advocates could agree on at least a broad outline of a bill.

Although our study did not focus on enacting local ordinances, our interviewees across the states referred to the coalition’s general effectiveness at the local level. Except in Illinois, anti-smoking coalitions and advocates seem, on balance, to be more effective at the local level than the tobacco industry, where industry financial contributions appear to be less meaningful than at the state level. Years of effective lobbying provide the tobacco industry with greater clout at the state level. But at the local level, where board members of the voluntary associations are often community leaders, the roles are reversed, and anti-smoking advocates may have a comparative cost and organizing advantage. In comparison to state legislators, local legislators may be more sensitive to constituents and less responsive to pressure from out-of-town lobbyists.9

Local Ordinances

The existence and strength of local ordinances appear to play more significant roles in state legislative outcomes than we initially suspected. We found evidence in several states that the existence of strong local ordinances creates an environment that facilitates the enactment of statewide legislation and affects tobacco industry strategy. In New York, for example, we found that an important determinant of enacting strong statewide legislation was that strong local ordinances already covered nearly 60 percent of the state’s population.

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9As one observer put it, “The tobacco industry can invite a legislator to dinner and advance the tobacco agenda. Advocates can generate grassroots pressure as opposed to traditional lobbying.” See also Samuels and Glantz (1991).
The local ordinances facilitated enactment of the Clean Indoor Air Act by showing public support for smoking restrictions. As one participant in the legislation stated, the existence of strong local legislation enabled legislators to vote for the bill and say that “we’re not changing your world.” And in Illinois, tobacco industry representatives acknowledged that the existence of local ordinances (as well as the costs of fighting, municipality by municipality) encouraged compromise on statewide legislation.

In Arizona and Texas, however, some legislators stated that the existence of local ordinances obviated the need for state legislation.\(^{10}\) Because the coalitions in these states were relatively ineffective, it is difficult to determine whether the legislators’ responses masked general opposition to statewide legislation or reflected dissatisfaction with the coalition’s efforts.

In addition, the existence of strong local ordinances will likely act as a barrier to the tobacco industry’s attempts to preempt local ordinances. This was most apparent in New York, where leadership changes resulted in senators from Nassau County assuming key leadership positions. Because Nassau County has one of the nation’s most stringent anti-smoking ordinances, the tobacco industry’s attempts to amend pending statewide smoking legislation to preempt local ordinances were effectively killed. The tobacco industry was more successful in preempting local ordinances in Illinois, but existing local ordinances were “grandfathered,” even where more stringent than the state law.

**Public Opinion and Media Attention**

In the six states visited, we found considerable evidence attesting to the fact that there is, generally speaking, broad public support for tobacco-control legislation.\(^{11}\) For example, in Florida and Minnesota, public opinion polls indicated that a substantial majority of the re-

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\(^{10}\)The early enactment of statewide legislation in Minnesota may have inhibited the development of significant local anti-smoking ordinances.

\(^{11}\)As Senator Volker stated during the New York Senate debate, “I think the reason that many of us here are especially voting for this legislation . . . relates to . . . the fact that many people in our society feel very strongly today that they don’t have to be and shouldn’t be subjected to smoke, in public places in particular.” NYS Senate Debates, pp. 3819–3820. New York State Department of Health (NYSDOH) General Counsel Millock added that the most important factor in passing the bill was that New Yorkers wanted it. “More and more people did not want their health threatened by others’ poor health habits and did not like the smell of tobacco smoke.” Letter dated 20 March 1990.
spondents favored additional restrictions on smoking in public places. And in Arizona, New York, and Texas, the existence of widespread local anti-smoking ordinances suggests that anti-smoking sentiment in these states also has substantial strength. These results are consistent with national public opinion polls that have found widespread public support for restrictions on smoking in public places. A 1985 Gallup poll found that an overwhelming majority of the public believes either in total smoking bans or in restricting smoking to designated areas.

Nevertheless, it seems clear that strong public opinion by itself is an insufficient legislative motivator to overcome opposition from an important constituency like the tobacco industry.\textsuperscript{12} One reason is that the intensity of the public's anti-smoking views remains in some doubt, as many legislators reported that they have heard little from their constituents on the issue.\textsuperscript{13} Although most legislators agreed that public opinion supported smoking restrictions, they were not under much constituent pressure to enact such restrictions. If anything, legislators in some states, particularly New York, received more pressure from the media than from their constituents.

Yet coalition staff members interviewed in each of the states remarked that a grass-roots campaign to urge constituent letter-writing and a media campaign to generate public support were primary coalition objectives. The legislators' responses suggest that these efforts have had only limited success in most of our study states.

Disparities across anti-smoking coalitions in the ability to mobilize media and public support appear to explain this limited success. In New York, the coalition maintained an aggressive media campaign that generated considerable favorable print and electronic media support for anti-smoking legislation. This campaign included press conferences, press releases, meetings with editorial writers, and generally keeping the media apprised of developments, and placed constant

\textsuperscript{12} For a similar conclusion regarding federal health care reform, see Oliver (1991).

\textsuperscript{13} In contrast, legislators often reported hearing from constituents opposed to tobacco-control legislation. However, most legislators have discounted the importance of this correspondence because it is often the obvious result of campaigns orchestrated by the tobacco industry. For a variety of reasons, we are not in a position to evaluate the tobacco industry's media campaigns across the states. We note, however, that we did not identify any specific media campaigns against anti-smoking legislation across our study states. But it is difficult to estimate the effects of the tobacco industry's general advertising campaigns on legislative attitudes.
pressure on the legislature to act.\textsuperscript{14} In Florida, recent efforts to improve media use have resulted in several strong editorials favoring anti-smoking legislation. On the other hand, the Illinois coalition seldom used the media to mobilize public support. Nor have the Arizona, Texas, or Minnesota coalitions developed a comprehensive media strategy.

**The State's Public Health Environment**

At the study's outset, we believed that the existence of other strong public health legislation in a state would suggest a state cultural and political environment favorable to enacting smoking restrictions. Thus, we used other public health legislation as a proxy for a state's cultural and political environment. Intuitively, one would expect a progressive state, such as New York or Minnesota, with other strong public health legislation to enact smoking restrictions. Likewise, one might expect states such as Arizona and Texas, with strong individualist and anti-government tendencies, to lack a strong public health tradition, thus complicating the attempt to enact smoking restrictions. And Illinois and Florida would fall somewhere in-between.

To a certain extent, the observed legislative outcomes are consistent with these cultural expectations, but the state's political culture is far from being a certain predictor of legislative outcomes. If it were a better predictor, New York would not have taken 13 years to enact smoking restrictions, Minnesota would have enacted significant additional restrictions between 1975 and now, and the Texas Senate would not have passed any anti-smoking legislation. Nor does reliance on cultural/political phenomena explain much about the underlying factors that determine legislative outcomes. That is, an intuitive grasp of a state's political culture will not necessarily provide insight into how and why legislative outcomes occur.

In addition, many of the people interviewed across the study sites reported that tobacco legislation is not closely related to other public health legislation. As an example, although New York has strong drunk driving and seat belt usage laws, the enactment of smoking legislation was independent of, and on a separate legislative track from, those issues. Indeed, opponents of smoking restrictions were unsuccessful in recruiting key legislators who had voted against seat belt laws on personal freedoms grounds to oppose smoking restric-

\textsuperscript{14}Hinz (1990) describes one incident where the anti-smoking coalition used the media to leak certain information that was difficult for opposing legislators to contradict.
tions. According to one key New York legislator, the form of opposition to anti-smoking legislation differs from other public health issues, where the questions are more technical and specialized. Because tobacco restrictions, like alcohol restrictions, affect a large industry as well as ingrained societal usage, the proposed legislation tends to be treated differently by the legislature.

We also reviewed an array of state demographic and political factors, such as state health rankings and party control of the legislature, to determine whether variation in these characteristics explains legislative outcomes. Despite several different ways of comparing these data, no significant patterns emerged.

THE ROLES PLAYED BY KEY ORGANIZATIONS

Although most anti-smoking groups contributed to coalition-sponsored activities, many were also engaged in activities independent of the coalition. Most of the time, the activities pursued by these organizations complemented those of the coalition, such as providing testimony before legislative committees, mobilizing existing volunteer networks, lobbying individual legislators, and conducting anti-smoking publicity and media campaigns. At other times, however, the activities pursued by particular organizations proved quite detrimental to the coalition’s legislative efforts. Perhaps more important, each organization has interests separate and apart from enacting anti-smoking legislation that may constrain its ability to participate in coalition activities. Most of these organizations are not single-issue interest groups.

Department of Health and Other Executive Branch Agencies

As one might expect, the state department of health served as the focal point of executive branch efforts to influence smoking-control legislation in most of the states studied. Occasionally, we found that other agencies (such as departments of education) and the governor’s office played tangential roles. Most state health departments and, more generally, executive branch agencies played supportive though relatively minor roles in the legislative process. In Illinois, for instance, the Department of Public Health took a position in favor of the anti-smoking legislation but did not take an active role in pressing the legislature for a stronger bill. And in Texas and Arizona, because of lobbying proscriptions, the state health departments have limited their activities to providing both the anti-smoking coalitions and the legislatures with technical information on the adverse health
effects associated with smoking and on alternative smoking-control measures.

The glaring exception to this characterization was New York, where, according to many observers, the New York State Department of Health played an extraordinary role. The department made smoking nothing less than a frontline issue and in many respects was principally responsible for the state's enactment in 1989 of one of the nation's most stringent anti-smoking bills.

In what turned out to be extraordinary bureaucratic maneuvering, the state's commissioner of health, frustrated over the failure of the legislature to enact a smoking-control bill, issued stringent anti-smoking regulations. Though subsequently overturned in court, the regulations served two critical functions. First, they raised public attention to the smoking issue and put the legislature on the defensive for failing to act. Second, the regulations framed the subsequent legislative debate in terms that favored smoking-control advocates. The tobacco industry opposed the regulations on procedural grounds, saying that the commissioner had no authority to issue them, rather than on the merits. When the regulations were introduced subsequently as legislation, the tobacco industry supporters were in a sense "boxed in" with respect to the substance of the legislation.

Organized Medicine and Public Health Groups

Despite the enormous toll that cigarette smoking takes on the public's health, we found that public health groups—in particular, the state public health associations—generally played a minimal role in the legislative process. With the exception of Illinois, where the state public health association was an active participant in the anti-smoking coalition, lobbying heavily to enact the bill, these associations often did little more than lend their names to coalition participation lists. In three states, none of the interviewees mentioned the state's public health association as playing any role whatsoever.

The role played by state medical societies, on the other hand, varied considerably across the six sites. In several states (Minnesota, for example) the medical society played an insignificant or minor role in enacting legislation or contributing to the legislative debate. In Arizona, coalition members had difficulty identifying the Arizona Medical Association's representative to the coalition. During our interviews, one Arizona respondent asked if we knew who the representative was, took the name down, and said "I really should give him a call." It should be pointed out, however, that despite the relative lack
of interest shown by the medical societies in these states, individual physicians in the same states, many of whom were members of the state medical society, were often quite active in the smoking-control movement.

In other states, however, the medical society took a more active stance on smoking-control legislation. Even though the New York Medical Society was criticized by some interviewees for not lobbying legislators more aggressively, the consensus view was that the society provided a reasonable amount of support for the legislation. Similarly, in Florida and Illinois, medical societies proved active members of the coalition and important assets for lobbying efforts on behalf of stronger anti-smoking legislation.

The only state where the medical society assumed a leadership position was Texas. There, a longstanding and tenacious anti-smoking activist, together with a handful of sympathetic colleagues and Texas Medical Association staff members, convinced the association's leadership and its members of the smoking issue's importance. In the last three years, the association passed no less than 17 anti-smoking resolutions and policies, ranging from statements of support for anti-smoking legislation to proscriptions against investing in tobacco company stocks. But perhaps the association’s greatest contribution to the anti-smoking cause is the commitment of their professional lobbyist's services to counter the tobacco industry's lobbying efforts.

Voluntary Health Associations

Our findings related to the roles played by the major voluntary health associations (the American Heart Association, the American Lung Association, and the American Cancer Society) varied considerably across the six states. Each of these organizations played important supportive roles within their respective state anti-smoking coalitions. For example, they lobbied visibly, participated in and funded coalition activities, testified before key legislative committees, and mobilized their networks of volunteers. Many, however, never assumed positions of leadership either outside or within the coalitions. In four of the six states studied, an individual or organization not affiliated with a voluntary health association played the pivotal role in the legislative process.

In part, the failure of these organizations to maintain leadership positions may be due to their cautious and conservative nature as well as to the competing demands they face for their resources and the fact that they are not single-issue organizations. We were told in several
states that, in effect, the major voluntary health organizations were generally reluctant to press forcefully for smoking-control legislation, particularly in public. Ironically, some of these organizations have not made smoking their top priority. One heart association staffer reported that although the association was concerned about the progress of anti-smoking legislation, its number one priority was to ensure the continued use of animals in scientific research.

On balance, nevertheless, we found that the voluntary health associations made important contributions to the development of smoking-control legislation. In all states studied, the voluntary associations were willing to draft model legislation, negotiate compromises between competing groups (both within and outside of the coalitions), participate in and fund coalition activities, and serve as careful advocates for anti-smoking legislation. Their participation increased the stature and credibility of the anti-smoking cause, and often provided the financial ability to hire professional lobbyists to compete with the tobacco industry.

Advocacy Groups

In contrast to the voluntary health organizations, the net contribution of the single-issue, anti-smoking advocacy groups is unclear. For the most part, independent advocacy groups, such as New York's Public Interest Research Group and Minnesota's Association for Nonsmokers' Rights, are integral and supportive members of the anti-smoking coalition. Because they tend to be more aggressive, they play an important role in mobilizing their constituencies and putting pressure on more mainstream coalition partners to accept a more extensive legislative agenda.

In some instances, however, advocacy groups were described as "radical" or "fringe" by legislators and coalition members alike, and consequently lacked the credibility that is accorded other partners in the anti-smoking coalition. We found this to be particularly prevalent in states with somewhat immature anti-smoking movements. One interviewee in Arizona went so far as to say that the "credibility of the coalition is jeopardized by the radical anti-smoking forces." A second interviewee, however, offered that the advocacy groups are useful for drawing attention to the issue and that the passion they are apt to display for the issue is "infectious."

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15Such fringe groups were not observed in all states. It may be that years of debate noted in some of the study states had the effect of moderating formerly fringe elements, making compromise more acceptable.
To a certain extent, this lack of credibility is due to the often confrontational style adopted by these organizations. The rhetoric and literature of these groups tends to be personal and ad hominem, as opposed to institutional, leading legislators to discount the content of the message. An anti-smoking advocacy group leader in Texas, for example, reported that an anti-smoking bill of any consequence would not pass the legislature “until the Speaker [of the House] died.”

**Tobacco Industry**

As indicated above, our knowledge of the role played by the tobacco industry in the political evolution of smoking-control legislation in the six states studied is, for the most part, secondhand. This is because, except in Illinois, representatives of the tobacco industry were unwilling to talk with us. Nevertheless, we are confident about our assessment of the industry’s role in the legislative process. In part, this confidence stems from the fact that the industry has acted as we expected, in its tactics and strategies, and our interviewees’ descriptions of the tobacco industry’s strategy is remarkably consistent across states. This consistency confirms our assumption that the tobacco industry’s activities and strategies were constant across the states.

Not surprisingly, the tobacco industry has demonstrated its willingness to exercise whatever political and financial resources it can muster, preferring behind-the-scenes maneuvering to public testimony and media campaigns. Beyond traditionally generous spending to influence legislative outcomes, the industry’s political power is enhanced through the hiring of well-known, in-state lobbyists with extensive client lists—including, in some instances, hospital associations and other health care groups—and who have longstanding, close relationships with key legislators.$^{16}$

The tobacco industry was repeatedly referred to as the “invisible enemy” by smoking-control advocates in several states. As reported by a number of observers in each study state, the industry’s strategy throughout the legislative session was to ensure that any anti-

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$^{16}$Whether the tobacco industry’s influence is pervasive institutionally, rather than limited to current leaders, is more difficult to determine. Most of the observers we interviewed tended to view the tobacco influence as tied to current leaders as opposed to representing a more pervasive institutional influence. If so, this suggests that anti-smoking advocates could have greater success in the future as the leadership changes. But the conclusion that tobacco lobby influence is tied to key legislators is tenuous, at best. Indeed, one anti-smoking legislator in Florida stated that it was simplistic to view tobacco industry influence in such narrow terms, especially given the industry’s extensive campaign contributions.
smoking bill was tied up in committee, with limited public debate.\textsuperscript{17} Texas provides a case in point. In that state, the industry has succeeded in blocking smoking-control legislation by concentrating its lobbying resources on the House side, where it has found that the Speaker and Chairman of the House State Affairs Committee are unwilling to bring such bills to a vote.

Along with the tobacco industry’s successful shifting of the legislative debate from public health to personal freedoms, the industry has engaged in what may be viewed as creative coalition-building efforts. By stressing the individual’s right to consume a lawful product, tobacco interests have garnered the support of nontraditional allies, such as labor and civil liberties organizations, but have sometimes found their traditional business allies in opposition. In Illinois and New York, for instance, the tobacco industry joined with labor groups to support legislation prohibiting discrimination against employees who consume a legal product during nonbusiness hours. The legislation was staunchly opposed by other business groups.

Additionally, the industry has been at least somewhat successful in gaining support among minority legislators, largely through their contributions to minority community activities. As has been widely reported, the tobacco industry has been an important source of funds for minority community activities. This support, and the concomitant marketing of cigarettes to minorities, has become very controversial. This presents a dilemma for minority legislators, who might otherwise oppose the tobacco industry. In New York, for example, several key minority legislators were noticeably absent for the final vote on the Clean Indoor Air Act,\textsuperscript{18} and minority legislators in other states have supported the personal freedoms arguments.

Another part of the tobacco industry’s strategy is to weaken (or kill) statewide anti-smoking restrictions by including nondiscrimination, smokers’ rights, or preemption provisions. From what we observed in our study, the enactment of nondiscrimination provisions appears to be a major tobacco industry goal nationally. The tobacco industry appears to have used a two-pronged approach to achieve this goal. As already described, tobacco industry supporters usually attempt to

\textsuperscript{17}According to one key observer in Florida, the tobacco industry relied on “power politics and money, and a deliberate strategy not to raise issues.”

\textsuperscript{18}It is important to note, however, that a backlash has emerged among minority community leaders in New York City who have objected to tobacco industry marketing efforts directed at their communities.
amend pending anti-smoking legislation with a nondiscrimination provision. Where no anti-smoking legislation is pending, industry supporters have submitted legislation, supported by labor groups, to prohibit employment discrimination against employees who consume lawful products during nonworking hours. This legislation, enacted recently in Illinois but not in New York, usually bypasses the health committees and is another example of the tobacco industry’s strategy to keep public debate to a minimum.¹⁹

A second goal appears to be the enactment of statewide laws preempting stronger local ordinances. In many states, including New York, Arizona, Texas, and Illinois, a substantial number of localities have passed anti-smoking ordinances, many of which are quite restrictive. The tobacco industry has viewed the potential enactment of statewide legislation as an opportunity to mitigate the effects of these ordinances, reasoning that a weak statewide bill containing a preemption clause is preferable to contending with a panoply of stringent local ordinances and no statewide law. In states where preemption already exists, the tobacco lobby focuses on nondiscrimination. As an example, the tobacco industry in Florida was willing to accept stronger anti-smoking language in return for a nondiscrimination provision.

The inclusion of a preemption, smokers’ rights, or nondiscrimination provision is in some respects a win-win situation for the tobacco industry. If legislation containing any of these clauses is enacted, the industry achieves an important victory, even if the price is somewhat stronger statewide legislation. On the other hand, the inclusion of a preemption or nondiscrimination provision may cause key legislators to withdraw their support for the bill, which, in turn, would lead to the bill’s defeat. During the 1990 Florida legislative session, a strong anti-smoking bill passed both houses, but the subsequent inclusion of smokers’ rights language split the legislative sponsors, effectively killing the legislation. Although the tobacco industry’s preference with respect to these two alternatives will differ depending on the particular provisions of the statewide law, the degree of local regulation, and so on, it is clear that either alternative offers some benefits to the industry.

¹⁹Indeed, the Illinois anti-smoking coalition admits to being caught off guard by this strategy.
Other Business Organizations

The tobacco industry spearheaded the effort to defeat anti-smoking legislation in all states studied, but at times they received the support of other industry groups that had a financial stake in the legislation. Typically, restaurant associations, vending machine operators, and other business groups joined the tobacco industry in opposing smoking-control legislation when they perceived that legislation posed a direct threat to their financial interests. However, these business groups were generally not extensively involved in debates over smoking-control legislation that did not directly impinge upon their operations. For instance, the restaurant associations in both New York and Minnesota initially opposed the clean indoor air bills in those states. Yet, when the legislatures weakened the provisions of the bill governing smoking in restaurants, the restaurant associations’ opposition waned.20

In general, we found that other business groups played only a minor role in anti-smoking legislation. This conclusion is somewhat tentative because these groups may have played a more substantive role than we were able to observe for two reasons. First, as noted above, tobacco lobbyists now represent an array of clients, making it difficult for us to determine how many groups actually supported the tobacco industry. In Florida, for example, a major industry group was allegedly very active behind the scenes in opposing smoking restrictions, but their representatives refused to meet with us. Second, business groups may have an incentive to mute their support of the tobacco industry, or at least not to be publicly identified as supporting it, because of conflicting interests. We were told in several states that many businesses welcomed state action to restrict smoking because it allowed business to limit smoking at the worksite by citing legislative requirements. Like other segments of society, business leaders also respond to growing evidence of smoking’s adverse effects on productivity and health care costs.

20 Much to the displeasure of the restaurant association in Minnesota, the restrictions on restaurant smoking, after being withdrawn from the House bill, were reintroduced to the 1975 legislation in the conference committee and consequently included in the final legislation. It should also be noted that studies have not demonstrated that smoking restrictions are bad for restaurant business.
4. DISCUSSION

In 1980, one commentator wrote that “While many Americans may claim to be opposed to cigarette smoking, few are willing to devote much effort to its eradication or limitation. The groups that do campaign against smoking are cautious and divided” (Sapolsky, 1980). Compared to the politically powerful tobacco lobby, anti-smoking groups in 1980 were weak and fragmented. Even though anti-smoking groups must still contend with their internal divisions, these groups are considerably more organized and effective than they were just a decade ago. Today, anti-smoking coalitions can compete with, and sometimes defeat, the tobacco industry. Even so, the challenge of enacting anti-smoking legislation over the tobacco industry’s sustained opposition should not be underestimated. The results of our case studies illuminate both how far the anti-smoking movement has progressed and how difficult it may be to obtain further smoking restrictions.

PUBLIC OPINION AND POLICY CHANGE

To a certain extent, the enactment of anti-smoking legislation (both at the state and local levels) represents a policy shift during the past decade. One obvious question is what accounts for the policy change. The most consistent explanation is perhaps the simplest: When asked what had changed over the years to facilitate the enactment of anti-smoking legislation, most people we interviewed said public attitudes. Taken at face value, this would suggest that the tobacco industry’s political power is eroding, and that the enactment of stringent anti-smoking legislation is inevitable. In reality, the observed trends are much more ambiguous.

As our results demonstrate, the public’s broad anti-smoking sentiment is hardly a guarantee that anti-smoking legislation will be enacted. It may well be that tobacco industry influence is on the decline, as anti-smoking advocates perceive, but it is hardly supine. Indeed, our results suggest a certain paradox in how the presumed public opinion trends appear to have shaped legislative outcomes. Each year the anti-smoking forces become that much stronger, as public opinion against smoking increases and anti-smoking coalitions become more effective. Despite these trends, the tobacco lobby strength in Illinois, Florida, Texas, and Arizona (among the states we
The results in two of our study states illustrate these points. Regardless of polls indicating greater public support for smoking restrictions in 1989 than in 1975, the 1989 Illinois legislation is weaker than a 1975 bill vetoed by then Governor Walker, and Minnesota’s anti-smoking advocates have been unable to expand significantly beyond the scope of the 1975 legislation. Does this indicate that on balance the anti-smoking forces were actually weaker in these states in 1989 than they were in 1975? There is no clear answer to this question, but it does suggest that state legislators may have begun to set limits on how intensively they are willing to regulate smoking behavior. In several states, including Illinois and Minnesota, observers noted that legislators were “tired” of the smoking issue or unwilling to go further at this time.1

In all likelihood, however, strong public support for smoking restrictions has been a factor in maintaining anti-smoking legislation on the legislative agenda. Another factor in the political evolution of tobacco-control legislation has been the accumulation of scientific evidence demonstrating the health hazards of smoking. Since these factors are present across states, the question becomes why strong anti-smoking legislation is enacted in one state but not in another.

HOW AND WHY STRONG ANTI-SMOKING LEGISLATION IS ENACTED

Under all but the most unusual circumstances, enacting strong anti-smoking legislation is neither a short-term nor an easy process. Lacking a sufficiently committed legislator or a cohesive anti-smoking coalition, as in Texas, Arizona, and Florida, strong anti-smoking legislation is unlikely to be enacted.

But the outcome in Illinois, where we identified both a committed legislator and a strong anti-smoking coalition, suggests that these two factors alone are insufficient for enacting strong tobacco-control legis-

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1 The Kingdon model described above focuses on coupling policy alternatives with legislative windows. In Minnesota, the absence of tobacco industry opposition to proposed legislation created such a window. We did not observe similar windows in the other study states. Except in Illinois, no observer suggested that smoking restrictions were off the political agenda if not enacted within a certain legislative session. And even in Illinois, legislators expected at most a one-session hiatus. At least in states with either a committed legislator or a strong anti-smoking coalition, there does not appear to be a political life cycle to anti-smoking legislation.
lation. If so, what other factors need to be in place for strong anti-smoking legislation to succeed? In New York, the state with the strongest legislation in our study, and perhaps in the country, the elements of success seem clear. First, a committed legislator kept the issue on the policy agenda for 13 years. Second, the executive branch, primarily the commissioner of health, committed significant political resources to its enactment. Third, a strong and inclusive anti-smoking coalition engaged in an aggressive grass-roots and media campaign to elicit public support for smoking restrictions. Fourth, the enactment of strong local ordinances created a climate for statewide legislation. Finally, changes in legislative leadership created a window for enacting the bill.

No other state had as many of the identified factors working in favor of stringent anti-smoking legislation as New York. In Minnesota, the other study state with strong anti-smoking legislation, the absence of tobacco industry opposition probably explains more about the legislative outcome than anything else.

Whether each of the factors identified in Sec. 3 as important for influencing legislative outcomes is in fact necessary for enacting strong anti-smoking legislation is a question we cannot answer from our study. Nor can we state with certainty which combination of factors is likely to succeed in any given state. But if New York is viewed as a model for enacting strong anti-smoking legislation, two factors in addition to a committed legislator and a cohesive anti-smoking coalition stand out as being important elements. First, having an active executive branch places additional political pressure on the legislature to act, especially when the executive branch makes such legislation a policy priority. Second, the existence of strong local ordinances creates a policy environment that facilitates the enactment of statewide smoking restrictions. Anti-smoking advocates can use local ordinances as leverage in persuading the legislature to enact such restrictions.

A Successful Coalition

In view of the importance of anti-smoking coalitions as legislative policy entrepreneurs, it is instructive to consider how and why some coalitions succeed and others fail. Several factors appear to explain why some coalitions are more effective than others.

First, to be effective in countering the numerous advantages of the tobacco industry, one observer maintained, requires relentless devotion to smoking legislation from both a full-time staff and a profes-
sional lobbyist. Tobacco legislation, he added, is all-consuming. Newly organized coalitions typically use staff persons to act as the chief lobbyist, whereas more mature coalitions hire professional and well-connected lobbyists. A coalition is better able to achieve its goals with a professional lobbyist, who is more able to compete with tobacco industry lobbyists. This seems clear from our interviews in Florida, Illinois, Texas, and Arizona, where the initial or continuing absence of a professional lobbyist impeded the coalition's progress.

Second, anti-smoking coalitions must be broad-based. Although we are unable to determine when a critical mass of organizations creates a formidable coalition, it seems clear that the following groups are the minimum necessary to sustain an effective legislative effort: the three voluntary health associations (the American Cancer Society, the American Heart Association, and the American Lung Association), the state medical society, and independent advocacy groups (such as Americans for Nonsmokers' Rights). Where these groups lobby on their own, as occurred in Florida until 1990 and in Arizona, the enactment of anti-smoking legislation is unlikely. When these groups participate in name only, without providing visible lobbying efforts, the result is also unlikely to favor smoking restrictions. Indeed, a go-it-alone attitude helps explain why some coalitions fail while others that maintain their cohesiveness succeed.

Successful coalitions, such as those in Illinois and New York, are able to convince a large number of important community organizations to participate in a group that will represent them in legislative negotiations. In New York, for example, many interviewees stated that the addition of the New York Public Interest Research Group provided an important source of grass-roots support lacking in previous coalition efforts. But in Florida, the nascent anti-smoking coalition did not contact senior citizens' groups about their willingness to participate, thereby losing a potentially important source of grass-roots strength.

Third, the successful coalitions established close working relationships with key legislative sponsors to develop appropriate policy al-

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2 Anti-smoking coalitions are generally unable to compete with the tobacco lobby in terms of money, access to legislators, or monitoring the legislative process, although they can compete on other grounds. For example, anti-smoking coalitions can compete for media attention, public opinion, local legislation, the moral high ground, and in providing information. The cost of securing and transmitting information is an important issue in political and economic theory. Greater financial resources seem to provide an advantage to the tobacco industry. But since tobacco information is freely provided by the government, the only cost to anti-smoking coalitions is to supply it to legislators and the media. Therefore, the tobacco industry's information cost advantage is somewhat attenuated.
ternatives and to coordinate legislative strategy. Likewise, such cooperation is needed to coordinate the various media, grass-roots, and lobbying approaches that combine to produce successful legislation. That cooperation was evident in New York and Illinois (which enacted legislation) but sorely lacking in Arizona and Texas (where no legislation passed).

Fourth, successful coalitions are able to mobilize public support for smoking restrictions through effective media and grass-roots campaigns. Our results suggest, however, that anti-smoking coalitions have not taken sufficient advantage of considerable opportunities to mobilize public opinion to support anti-smoking legislation.

Finally, successful coalitions need time to develop organizational and strategic cohesiveness. In our study states, newer coalitions (such as Arizona's) fared less well than those that had developed over several years, in part because the more ambitious members of the newer coalitions pushed a more aggressive legislative agenda, making it difficult to unite the coalition. This suggests that coalitions go through a maturation process that influences their lobbying strategies and ability to frame the issue most effectively. Even in mature coalitions, however, the failure to agree on a legislative strategy, particularly what compromises are acceptable, leaves the coalition vulnerable to costly internal splits.

**Framing the Smoking-Control Debate as a Public Health Issue**

How the issue of smoking restrictions is framed is an important component of the legislative debate and outcome. In all states, but particularly those in which the scientific debate has receded into the background, the tobacco industry has attempted to shift the nature of the debate from the credibility of the scientific evidence to personal freedoms, and has lobbied extensively for the inclusion of nondiscrimination clauses in tobacco-control legislation. Although the results of these efforts have been mixed, the ability of the tobacco industry to shift the debate to its advantage after having lost the scientific argument is, in some ways, a remarkable demonstration of creative lobbying. To regain the initiative, anti-smoking advocates will need to be equally creative.

For example, anti-smoking advocates will need to develop a strategy that responds to the personal freedoms arguments and to the new coalition assembled by the tobacco industry. Anti-smoking advocates must work hard to shift the debate back to public health, by making the case, for instance, that smokers impose external costs on non-
smokers, particularly children, and higher health costs generally on society. To be successful, advocates will also need to force the debate back into the public arena and away from the private domain of the lobbyists. Public debate is important because it keeps attention on tobacco smoke as a policy problem justifying legislative intervention. Successful framing of the issue helps to supply a rationale for governmental intervention and regulation of essentially private activities.\(^3\)

Framing the issue in public health terms will not necessarily lead to strong anti-smoking legislation, but allowing the tobacco industry to frame the debate as one of personal freedoms certainly makes it very difficult to obtain such outcomes. At a minimum, it makes it difficult for legislation to pass that does not include nondiscrimination or other smokers’ rights provisions. Most anti-smoking advocates we interviewed were primarily concerned with the potential for smokers’ rights provisions to undermine the broader smoking restrictions. What remains unknown at this point is the extent to which provisions that prohibit discrimination based on smoking behavior or that protect smokers’ rights affect either compliance with anti-smoking laws or overall cigarette consumption. Do these provisions reduce compliance with the laws, or even undermine other provisions restricting smoking in public places? Because the tobacco industry continues to focus on enacting these provisions, it is important to determine whether they are entirely symbolic or actually have a deleterious effect on anti-smoking legislation.

**PUBLIC POLICY IMPLICATIONS**

**Tobacco and Other Public Health Legislation**

Our results indicate that the relationship between tobacco-control legislation and other public health legislation appears to be less important than we initially thought. That is, the fact that a state either has other strong public health legislation or lacks a public health tradition will not necessarily predict anti-smoking legislation outcomes. Perhaps because of the tobacco industry’s lobbying clout, tobacco legislation tends to be considered on a separate legislative track.

In view of the apparent disjunction between smoking legislation and other public health legislation, some of our specific findings may not

\(^3\)See, for example, Rabin (1991) on the need to provide a rationale for governmental regulation of smoking behavior.
be applicable to other public health initiatives. At the same time, we expect that important future public health debates will also involve tensions between financially and politically powerful industries, public health, and individual rights. Thus, some of our broader findings may well be applicable to a range of expected public health legislative initiatives.

For instance, we anticipate that variations of the strategies and arguments used in the tobacco-control debate will be repeated in legislative initiatives to restrict firearms and alcohol use. To be sure, the political processes and outcomes will differ as a function of the particular configuration of interest groups. But the strategies and arguments reviewed in this study are likely to presage future public health debates. In addition, attempts to enact public health legislation affecting such industries must be seen as long-term battles, with limited short-term expectations, for which long-term strategies are needed. Despite certain recent legislative successes in limiting access to handguns and automatic assault weapons, it seems barely imaginable that strict gun controls, based on a public health rationale, can be enacted at this time. We would simply point out that as recently as 15 years ago, widespread smoking restrictions seemed equally remote.

**Pursuing a Strategy to Enact Local Ordinances**

Although strong statewide legislation is likely to remain a central strategic goal for anti-smoking advocates, the difficulty of enacting such legislation suggests that anti-smoking advocates should consider devoting more resources to enacting local ordinances. A complement-ary local strategy has the potential for imposing smoking restrictions that might be even more stringent than corresponding statewide legislation. It also appears that the very existence of a large number of local ordinances can decrease the likelihood of enacting statewide legislation that contains a preemption provision. Just as important, enacting local ordinances provides additional experience about the costs, enforceability, and effects of smoking restrictions, and sustains smoking restrictions as a viable policy problem and political issue. Local ordinances can therefore serve as a catalyst for strong statewide legislation.

In several of the states studied, anti-smoking advocates were quite successful in passing local ordinances, at times producing impressive results. This finding held even in states such as Texas and Arizona, which traditionally have opposed government regulation of private behavior. The success of anti-smoking groups at the local level can, in
part, be attributed to the relative ineffectiveness of tobacco industry opposition. Historically, the tobacco industry has concentrated its lobbying efforts at the state level, where presumably through years of effective lobbying, it has wider influence than it has at the local level.\textsuperscript{4} This allows anti-smoking advocates, who often have close political ties at the local level, to have greater influence in enacting local ordinances.\textsuperscript{5}

Another reason for focusing on a local strategy is the possibility that state legislators may be reluctant to consider more expansive antitobacco legislation. Since the passage of strong anti-smoking legislation in New York in 1989, advocates there have struggled to enact statewide legislation placing severe restrictions on cigarette vending machines. Once the relatively clean issue of imposing restrictions on public smoking is addressed, more difficult antitobacco issues involving nontobacco business interests are likely to emerge and encounter ever greater legislative obstacles.

Relying on a local strategy alone, however, has two potential drawbacks. One is that, even if largely successful, it inevitably leaves a certain portion of the state's citizens without any restrictions, and will most likely result in wide within-state variation in regulatory stringency. Another is that some states will be more resistant to a local strategy than others. As we detail in the Illinois case study, for example, supporters of the Illinois legislative compromise argued that the preemption provision meant little because anti-smoking advocates were having limited success in downstate communities. In those states, a statewide strategy may be a more viable alternative.\textsuperscript{6}

**Leadership by Medical and Public Health Organizations**

In general, we anticipated considerably more leadership from public health associations, state medical societies, and voluntary health associations than we observed. We were surprised that these groups were sometimes marginal participants and rarely asserted leadership in coalitions' legislative efforts. With the exception of Illinois, state public health associations in particular appeared to have no influence

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\textsuperscript{4} Some observers close to the tobacco industry suggested that it is difficult and expensive for the tobacco lobby to fight every proposed local anti-smoking ordinance.

\textsuperscript{5} For a similar conclusion, see Samuels and Glantz (1991).

\textsuperscript{6} A third possible drawback is that legislators may conclude, as some in Arizona and Texas stated, that there is no need for statewide legislation given the presence of a large number of stringent local ordinances. We do not expect this argument to prevail when opposed by a well-organized anti-smoking coalition.
on legislative outcomes, even though improving public health is their primary goal. Although we recognize that these groups have other significant legislative and organizational interests, the health effects of tobacco smoke are central to each of their stated missions.

In assessing the roles these organizations played in the development of smoking-control legislation, two important points emerge. For one thing, according to many observers, support from these organizations appears to be necessary to enact anti-smoking legislation. In all states, the medical society lent credibility and legitimacy to the medical and scientific arguments favoring stricter tobacco-control legislation, even if reluctant to assume a leadership position. It also seems clear that anti-smoking initiatives would have difficulty overcoming medical society opposition.

For another, the objectives behind medical society and voluntary health association involvement in the smoking issue are mixed and complex. On the one hand, their members and staffers voiced genuine concern over the adverse health effects of cigarette smoking, and believe that it is their obligation to devote resources to support stringent anti-smoking legislation. On the other hand, each organization has a myriad of lobbying efforts that usually focus on economic issues. Medical societies, for instance, lobby heavily on physician reimbursement and medical malpractice liability.7 These economic interests place certain constraints on efforts devoted to public health issues. Judging by our observations, however, visible acts of support for anti-smoking and other public health legislation may also help advance these organizations' other legislative interests.

By itself, leadership by medical and public health groups may not ensure the enactment of strong anti-smoking legislation. But exercising such leadership sends an unmistakable message that public health concerns must be addressed by state legislatures. It is thus important for these organizations to go beyond their current educational and supportive roles to take more active leadership roles in legislating smoking restrictions.

**Conceptual Models Explaining Public Health Legislation**

Our results also suggest that none of the theoretical models explaining the legislative process generally provides a complete framework for evaluating anti-smoking legislation across our study states. Each

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7Legislators in several states complained that medical society lobbyists were visible only on issues affecting economic interests.
theory provides some insight into why legislative initiatives succeed or fail in various states. For example, the entrepreneurial model helps explain the importance of the anti-smoking coalition, and the Kingdon model helps clarify the importance of keeping smoking on the legislative agenda. Likewise, the demands of the tobacco and anti-smoking interest groups are surely important but do not account for all outcomes we observed, particularly those in Illinois, New York, and Minnesota. And the political culture model explains some of the observed outcomes but fails to predict many other outcomes. For instance, this model would likely posit early enactment in New York and only cursory consideration in Texas. As we have seen, neither of these predictions is accurate.

Perhaps a new model explaining the enactment of public health legislation is needed. At this point, we are not prepared to specify such a model. We note, however, that the entrepreneurial politics model more closely explains our observed outcomes than the other models, especially in describing the importance of policy entrepreneurs. Given the importance of anti-smoking coalitions in our results, it seems likely that policy entrepreneurs will be essential for enacting other controversial public health legislation.

**Lessons for California**

Probably the most important lesson learned during the course of the study is that, for several reasons, we are convinced that stringent statewide smoking-control legislation can be enacted in California and in the vast majority of the states. First, California public opinion overwhelmingly favors additional restrictions on smoking in public places, and the fraction of the public in favor of such restrictions can be expected to grow as the scientific evidence on the health effects of passive smoking is more widely disseminated. And because California has the lowest prevalence of cigarette smokers in the nation, California legislators can expect widespread support for enacting statewide smoking restrictions. Second, as seen most clearly in the New York case study, states can enact strong anti-smoking legislation, despite formidable tobacco industry opposition. And finally, the substantial proportion of the California population already covered by local smoking ordinances suggests an environment where additional restrictions are unlikely to be seen as arbitrary or cumbersome.

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8Hinz (1990) reached a similar conclusion in his case study of the New York anti-smoking legislation.
Appendix A
NEW YORK CASE STUDY

INTRODUCTION
Given New York’s progressive public health image, one might intuitively expect New York to enact strong statewide anti-smoking legislation. And, indeed, in 1989, New York passed what is arguably the strongest statewide anti-smoking legislation in the nation. But this was the culmination of a 13-year battle, suggesting that the process of enacting the legislation was arduous and in some doubt until the final vote. The passage of this bill marked a strong about-face for the legislature, which had opposed previous anti-smoking efforts by a key state assemblyman. In part, this turnaround was the result of critical leadership by the governor and his health commissioner, the passage of local ordinances throughout the state, the efforts of a well-organized anti-smoking coalition, and the persistence of key legislative supporters.

BACKGROUND
Statewide Smoking Legislation and Regulatory History
The Clean Indoor Air Act of 1989 requires nonsmoking areas in workplaces, restaurants, and public places such as auditoriums, theaters, schools, public transportation vehicles, and public buildings. One of its features is that the bill gives enforcement powers to local governments. Because the law does not include a preemption provision, localities are free to enact more stringent regulations.

The minimum age to buy or possess cigarettes or smokeless tobacco in New York is 18 (including the use of vending machines), and the sale of tobacco to minors is prohibited. Signs must be posted at the point of sale. Currently, there are no statewide laws regarding the minimum age for receipt of tobacco samples, but legislation has been introduced to eliminate cigarette vending machines and the distribution of free samples.

Although the New York State Department of Health (NYSDOH) has limited enforcement responsibilities under the Clean Indoor Air Act, the department is actively involved in tobacco control and prevention. Limiting the consumption of cigarettes has been a priority for the
NYSDOH. New York has established a state coalition for prevention and control of tobacco use, but it has no annual funding.

Local Smoking Ordinances

New York has some of the strongest local anti-smoking ordinances in the nation. Both Suffolk and Nassau Counties (Long Island) restrict smoking in a wide range of public places, including private worksites. Just as important, some upstate communities (traditionally more conservative), such as Monroe County (Rochester), have imposed similar restrictions. Each of these ordinances was enacted before the statewide act in 1989.

In New York City, Mayor David Dinkins announced in October 1990 that cigarette ads will be banned from the city subway system. Ads will also be barred from city-owned billboards and roofs of taxis. More important, on November 27, 1990, Mayor Dinkins signed into law a ban on cigarette vending machines accessible to minors. The new law prohibits vending machines in public places such as hotel lobbies, grocery stores, and other places accessible to minors. It will not prohibit machines in nightclubs, taverns, and hotel bars, but the ban affects 85 percent of the city’s licensed cigarette machines. New York City also enacted a ban on free distribution of cigarettes.

By the time the Clean Indoor Air Act was enacted, 10 local communi-
ties, covering approximately 67 percent of the state’s population, had already enacted stringent anti-smoking ordinances. As we describe below, this made it difficult for the legislature to enact a law that pre-
empted local legislation.

INTERVIEW RESULTS

We found that several factors distinguish New York from other states in explaining why and how such stringent anti-smoking legislation was enacted. More than in other states, the legislation had the active support of the governor and the aggressive lobbying of the NYSDOH. In an ironic twist, strong local ordinances “preempted” the tobacco industry’s own statewide preemption strategy. And an active anti-smoking coalition organized grass-roots support for the legislation.

Hinz (1990) provides a valuable and thorough description of the events that culminated in New York’s Clean Indoor Air Act. As a for-
mer member of the anti-smoking coalition, Hinz stresses the role of the coalition as the dominant reason for the legislation’s passage. Although our interviews suggest that much of his account is factually
accurate, our interviews also suggest that other factors, such as the roles of the executive branch and key legislators, predominated. As we detail below, the coalition's work was a necessary, but not sufficient, determinant of the legislative outcome.

**Legislative Chronology**

Because the history of the Clean Indoor Air Act is quite complex, a brief summary of the major legislative events will facilitate an understanding of the remaining narrative. For 13 years, Assemblyman Alexander "Pete" Grannis was the primary legislative sponsor of the anti-smoking legislation. Most of the time, however, the legislation was blocked in the Senate Health Committee and by the Senate leadership, largely at the behest of tobacco industry lobbyists.

In response to this deadlock, Dr. David Axelrod, New York State's Commissioner of Health, convened the Public Health Council to issue regulations restricting smoking in public places. Issued in 1987, the regulations went beyond what the legislature had been contemplating and were immediately challenged in court. The regulations were overturned as a usurpation of legislative prerogatives, thus returning the issue to the legislature.

Anti-smoking legislation was almost enacted in 1988, but was rejected by its sponsors after the Senate added an amendment preempting local ordinances. As described below, the anti-smoking coalition split over whether to endorse the 1988 bill, but finally rejected a compromise position (that is, a stronger bill with preemption) under prodding from Dr. Axelrod. In 1989, the same legislation without preemption made it through the Senate Republican Conference and was enacted. Once enacted, the Senate and Assembly leadership cooperated in a series of parliamentary moves to speed sending the bill to the governor before the tobacco industry could organize its opposition.

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1 Although many observers described the legislative debate as nonpartisan, it seems clear that Democrats were more committed to enactment than Republicans. For many years, the legislation was pushed by the Democratic Assembly and blocked in the Republican Senate, in part for lack of strong Senate sponsorship. In general, the Senate is more conservative and sympathetic to business interests. Given Republican control of the Senate, Governor Cuomo, a Democrat, could not exert direct pressure on the Senate to act.


3 Several legislators stated that the irony of Republican senators supporting preemptive legislation was not lost on the Republicans.
The Legislative Debate

By the time the 1989 legislation reached the floor of the Assembly and Senate, much of the drama was gone. As one legislator put it, "this legislation obviously is not something that is particularly foreign to most of us." Instead of a debate on the scientific or personal freedoms issues, most of the legislative debate was concerned with technical interpretations of the legislation, such as whether a restaurant would be required to allow waiters and waitresses to work only in nonsmoking sections if they so desired. But other parts of the debate, especially in the Senate, were considerably more philosophical and eloquent.

The primary reason for the limited debate was the accumulation of scientific evidence demonstrating the health hazards of smoking over the 13 years of considering anti-smoking legislation. By 1987 the weight of the Surgeon General's reports on smoking made it impossible for the tobacco industry to make a case on the scientific evidence. In particular, the emerging evidence of harm from secondhand smoke seemed to blunt the tobacco industry's personal freedoms arguments, and transformed the debate from smoking as a nuisance to smoking as a health threat. Even though some questioned the extent of harm from secondhand smoke, smokers' rights arguments were not as effective in New York after the report on passive smoke was issued.

Having "lost" on the scientific merits, the tobacco industry focused on personal freedoms and governmental interference arguments. As in other states, the tobacco industry attempted to frame the issue as one of civil liberties and civil rights, especially the rights of smokers to nondiscrimination in employment. The tobacco industry also argued that economic harm would result from conflicts between employer and employee and from disputes between smokers and nonsmokers. None of these arguments was ultimately persuasive, although the Senate debate suggested that many Republicans were seriously concerned about these issues. For most legislators, however, the public health arguments outweighed all of the tobacco industry claims. The

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5NYS Senate Debates, 5 July 1989, pp. 3758–3824. For example, Senator Gray stated that "this is a law whose time has come. For I believe that government is supposed to do for people what they can't do for themselves; and, obviously, the nonsmokers have not been able to control their environment." NYS Senate Debates, July 5, 1989, pp. 3820–3821.

6In particular, see the comments of Senator Bruno during the Senate debate. NYS Senate Debates, July 5, 1989, pp. 3789–3794.
response by one Senate Republican leader is instructive. He had opposed seatbelt laws on personal freedoms grounds but supported smoking restrictions because of the harm caused by passive smoke.

Despite some support from minority legislators, business opposition to the Clean Indoor Air Act gradually faded, in part because many of the largest State Business Council members had already instituted smoking policies to meet local ordinances without incident. Only the restaurant association strongly supported the tobacco industry position, but most business groups supported preemption. Anti-smoking advocates were also able to cite studies from other cities (including Aspen and San Francisco) showing no loss of business following similar legislation, and New York's own experience with strong local ordinances suggested that economic losses would not occur.

Other observers argued that the tobacco industry relied more on political power than on persuasive arguments. As one key legislator stated, "The industry's arguments were specious apart from the industry's power." This suggests another reason why the debate had ebbed by 1989. If the industry was relying on key legislators to attach preemption amendments to the legislation, it would not be in their interest to engage in a public debate with anti-smoking proponents. Instead, it suggests a strategy of relying on behind-the-scenes maneuvering where shrewd lobbyists can be most effective.

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7In New York, as in other states, the tobacco industry has been an important source of funds for minority community activities. Thus, minority legislators have been generally supportive of tobacco industry positions, and several minority legislators were absent for the final vote on the Clean Indoor Air Act. Along with legislative support for tobacco industry issues, however, a backlash has emerged among some minority community leaders in New York City who have objected to industry marketing efforts directed at minority communities.

8For many of these groups, supporting preemption was tantamount to finding a way to kill the bill. Others, however, expressed a legitimate concern for having uniform standards. By most accounts, the restaurant association's lobbying efforts on smoking were very effective and resulted in fewer smoking restrictions in restaurants than anti-smoking advocates had anticipated.

9In this sense, preemption represents a win-win situation for the tobacco industry. If legislation with preemption is enacted, tobacco lobbyists have attained an important victory, even if the tradeoff is for stronger legislation. But if preemption language kills the bill, so much the better. The fact that the tobacco lobbyists relied on a strategy of including preemption language and did not even introduce anti-discrimination language as part of the Clean Indoor Air Act suggests that the personal freedoms issues were unpersuasive. A separate bill providing for smokers' rights has gone nowhere, but a broader bill prohibiting employment discrimination based on private use of a legal product was recently enacted. After a threatened veto, the bill was withdrawn. It was supported by a coalition of labor and tobacco interests and enacted over the opposition of business groups.
Except for the issue of who would have primary enforcement responsibility (as discussed below), questions regarding enforcement costs and regulatory burdens were not significant. During the legislative debate, one Senator pressed workability and practicability issues, such as engaging the "cigarette police," but he received little support.

Finally, it appears as though anti-smoking legislation in New York is not closely tied to other public health legislation. Although New York has strong drunk driving and seatbelt usage laws, and many observers indicated that the public health climate in New York facilitated passage of the Clean Indoor Air Act, the enactment of anti-smoking legislation was independent of, and on a separate legislative track from, those issues. Indeed, opponents of smoking restrictions were unsuccessful in tying opposition to seatbelt laws on personal freedoms grounds to smoking restrictions. According to one legislator, the form of opposition to anti-smoking legislation differs from other public health issues, where the questions are more technical and specialized. Because tobacco restrictions, like alcohol restrictions, affect a large industry as well as ingrained societal usage, the battles tend to be much larger and are treated differently by the legislature.

The Role of the Governor and the Department of Health

Perhaps the clearest difference from other states emerged in the active role of Governor Cuomo and Health Commissioner Axelrod. Interviewees consistently cited the executive branch's activities as a critical factor in shaping the legislative outcome. According to many observers, the NYSDOH made smoking a frontline issue and created the climate that facilitated legislative enactment. Several observers commented that the NYSDOH was instrumental in disseminating scientific evidence about the harms from smoking. And Commissioner Axelrod was responsible for rejecting the 1988 bill that included a preemption provision and in chastising the anti-smoking coalition for its willingness to compromise on preemption to get a strong bill.

Almost every person interviewed suggested that Axelrod's most important contribution was to initiate the process of issuing smoking regulations in 1987 when anti-smoking legislation was hopelessly blocked in the Senate. Although these regulations were overturned in court, they ultimately served two critical functions. First, they

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10To be sure, legislators stressed that Axelrod, rather than Cuomo, was the driving force.
turned public attention to the smoking issue and put the legislature on the defensive for not acting. The regulations generated considerable publicity and were, according to most observers, the primary impetus for legislative action.\textsuperscript{11}

Second, and perhaps more important, the regulations framed the subsequent legislative debate. By attacking the regulations on procedural rather than on substantive grounds, opponents were in a sense "boxed in" to the core of the regulations as a basis for legislative action. In effect, according to one key legislator, opponents of the legislation had conceded the merits of the debate and were relegated to focusing on preemption. This legislator added that "once the notion of an anti-smoking bill was accepted, the debate shifted from should to when." In this view, opponents of smoking restrictions outsmarted themselves.

At the time the bill was signed into law, Governor Cuomo announced the formation of a Commission on Smoking OR Health. The avowed purpose of the commission, which is to include representatives of various business, labor, health, and volunteer associations, is to "continue the campaign against this addictive substance" by suggesting new legislative and policy initiatives.\textsuperscript{12} Recently, for instance, the commission endorsed legislation to place restrictions on cigarette vending machines. To anti-smoking advocates, the commission represents an opportunity to broaden and institutionalize the anti-smoking coalition. According to several observers, it is too soon to determine what effect the commission will have on subsequent anti-smoking legislation, but it provides an independent channel for communication between the executive and legislative branches.

**The Role of Key Legislators**

The key events in moving the legislation onto the Senate floor in 1989 were leadership changes in the Senate following the 1988 election. This shift appears to have been one of both power and philosophy.

\textsuperscript{11} Placing the onus on the legislature, and particularly on the Senate, did little to endear Axelrod to Senate Republicans. Even some supporters of the legislation objected to the attempt to usurp the legislature's role by issuing regulations. According to one participant, Axelrod's authority was the most contentious issue among Republicans. The Republican Senate's personal antipathy toward Axelrod led the Senate to restrict the Department of Health's enforcement responsibilities by focusing enforcement at the county level. Thus, the legislation does not authorize the NYSDOH to promulgate statewide enforcement regulations. Localities may opt, however, to have the NYSDOH be responsible for enforcement.

\textsuperscript{12} Governor's press release, 5 July 1989.
The former Senate leader retired, and the Chairman of the Health Committee moved to chair the Finance Committee. Both were upstate legislators who were sympathetic to tobacco industry arguments and were able to block the legislation. They were replaced by members from Nassau County who were philosophically comfortable with smoking restrictions, and who could not reasonably support preemption given the strong local ordinances in their home districts. One advocate put it bluntly: “The change in [the Senate] Health Committee Chairman made the difference.” The new Health Committee Chairman, Michael Tully, decided to push the legislation through conference with support from the new Senate leadership.13

It thus appears that key legislators were integral to the process of enacting anti-smoking legislation. One key supporter said that “you can’t get it done unless there’s fire in the belly—you can’t carry [someone else’s] water.” Without the persistence of Assemblyman Grannis and the timely leadership changes in the Senate, especially Senator Tully’s willingness to push a “clean” bill through the Senate, it is unlikely that the final legislation would be as strong as it is. Public sentiment, along with the Cuomo Administration’s and the anti-smoking coalition’s aggressive efforts, would likely have generated some legislation, but the tobacco industry would have had a better opportunity to include preemption or anti-discrimination provisions in return for not blocking enactment.

Likewise, it appears that the tobacco industry influence in New York is also tied to key legislators.14 Until the Senate leadership changes in 1989, the tobacco industry was able to rely on a few key legislators to block anti-smoking legislation. Ironically, the tobacco industry could have secured weaker legislation in 1986, before the Public Health Council’s regulations, but instead used its power to block the legislation.

**The Role of the Anti-Smoking Coalition**

From both Russell Hinz’s account and our interviews with coalition participants, it seems clear that the coalition attributes enactment of

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13Not only were the two new leaders personal friends, but the new majority leader had promised greater latitude for committee chairmen. Thus, the anti-smoking legislation benefited from changes in how the Senate was run.

14As in most states, years of effective lobbying and substantial campaign contributions provided tobacco lobbyists with especially close connections to the leadership. Just as important, tobacco lobbyists are among the most respected and influential lobbyists, with major client lists. Nevertheless, one key legislator stated that “The tobacco industry can’t initiate, but it can block legislation.”
the Clean Indoor Air Act to its efforts. Although most other observers agree that the anti-smoking coalition played an important role in enacting strong anti-smoking legislation, they treated the coalition's efforts as subordinate to the roles of the executive branch and key legislators. We agree with the latter assessment.\(^{15}\) Whether this legislation could have been enacted without the coalition's efforts is a much more difficult question to answer. Certainly, the coalition contributed heavily to the overall anti-smoking climate, particularly as a countervailing lobbying presence to the tobacco industry and in educating the public about the hazards of smoking. Just as important, the coalition helped translate latent public support into effective lobbying. But the coalition's public split in 1988 over support of the pre-emption legislation did cost it some support in the legislature.\(^{16}\)

It also appears that the coalition strengthened itself after the 1988 debacle by adding new groups, such as the New York Public Interest Research Group, and becoming more focused. By all accounts, the coalition did an excellent job in generating media coverage during 1989, which kept the pressure on the legislature until the legislation was enacted. Through mail campaigns and press conferences, the coalition was able to mobilize latent public sentiment in favor of the legislation. Several observers suggested that the coalition was much better organized and more effective in 1989 than in 1988.

On balance, the coalition seemed to be more effective than the tobacco industry at the local level, where industry financial contributions were less meaningful than at the state level. Years of effective lobbying provide the tobacco industry with greater clout at the state level in New York. But at the local level, where board members of the voluntary associations are often community leaders, the roles are reversed.\(^{17}\) At least in New York, the local advantage proved decisive for the coalition.

Despite its obvious success in New York, at least one coalition member expressed caution in interpreting the results. He maintained that

\(^{15}\)To us, it seems somewhat hyperbolic to argue, as one former advocate did, that the strength of the legislation is directly proportional to the strength of the coalition.

\(^{16}\)As Hinz describes in his case study, the split occurred because the coalition failed to define its goals and establish a bottom line position. According to Hinz, "The Great Smoking Debate' of 1988 ended the way the tobacco industry wanted—they divided the advocacy community and won" (p. 13). This suggests that even mature coalitions are subject to a divide and conquer strategy in the pressure of enacting legislation.

\(^{17}\)As one observer put it, "The tobacco industry can invite a legislator to dinner and advance the tobacco agenda. Advocates can generate grassroots pressure as opposed to traditional lobbying."
to be effective in countering the numerous advantages of the tobacco industry required relentless devotion to smoking legislation from a full-time lobbyist, preferably a professional one. Tobacco legislation, he added, is all-consuming. Russell Hinz reached similar conclusions in his New York case study.

The Effects of Local Ordinances as a Measure of Public Opinion

Regardless of any formal public opinion polls in New York, one fact suggests that public sentiment strongly favors smoking restrictions: Between 60 and 70 percent of the public is covered by stringent local anti-smoking ordinances and there has been no attempt to overturn them. Aside from the serendipitous fact that two legislators representing counties with strong local anti-smoking ordinances emerged to hold positions of power in the Senate, observers were nearly unanimous in their view that the local ordinances facilitated enactment of the Clean Indoor Air Act by showing public support for smoking restrictions. As one participant in the legislation stated, the existence of strong local legislation enabled legislators to vote for the bill and say that “we’re not changing your world.”

The few public polls available support this conclusion. For example, a 1984 poll in Nassau and Suffolk Counties showed that 72 percent of those polled supported workplace restrictions and 87 percent supported smoking restrictions in restaurants. In addition, smoking prevalence in New York continued to decline throughout the years of legislative debate. Thus, each legislator knew that roughly 70 percent of constituents were nonsmokers. And most of the interviewees sensed that people’s attitudes toward smoking had changed and were willing to impose restrictions.

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18Another participant added, “The experience in those areas covered by local laws was positive. The restaurant industry did not collapse, plants did not close, smokers did not get carted off to jail.” Letter from Peter J. Millock, General Counsel, NYSDOH, 20 March 1990.

19A poll of 589 residents of Nassau and Suffolk Counties in November 1984 by New York Newsday. Yet several legislators noted that there was little constituent pressure for enacting statewide legislation. Most of the pressure came from the coalition, not from voters.

20As Senator Volker stated during the Senate debate, “I think the reason that many of us here are especially voting for this legislation . . . relates to . . . the fact that many people in our society feel very strongly today that they don’t have to be and shouldn’t be subjected to smoke, in public places in particular.” NYS Senate Debates, pp. 3819–3820. NYSDOH General Counsel Millock added that the most important factor in passing the bill was that New Yorkers wanted it. “More and more people did not want
The Role of Organized Medicine and Public Health Groups

Depending on the interviewee, the New York State Medical Society was either an integral component of the anti-smoking coalition or a "free rider" merely providing a name. Some legislators were especially critical of the medical society for not being more active in lobbying the Senate, and coalition members also expressed disappointment that smoking was not a medical society priority. But several other observers suggested that the society provided access to Senate leaders and by being part of the coalition, legitimated coalition arguments on health and scientific matters. And individual physicians were active in supporting smoking restrictions at the local level. As one key legislator put it, "Medical society opposition would have hurt, but the absence of strong support was neutral." In addition, the New York State Journal of Medicine has devoted several of its issues exclusively to cigarette smoking, most recently in January 1989.

More important, the New York State Association of County Health Officers (NYSACHO) was an active participant in the coalition and led aggressive anti-smoking campaigns in the counties. NYSACHO was a critical lobbying factor in opposing preemption and in creating popular local support for smoking restrictions. The county health officers also refuted tobacco industry claims that anti-smoking provisions created "civil war" between smokers and nonsmokers.

In contrast, the New York State Public Health Association appears to have been minimally involved. Although part of the coalition, the association played a relatively minor role in enacting the legislation.

CONCLUSION

For both anti-smoking advocates and tobacco industry supporters, the most important question now is, What next? The enactment of the Clean Indoor Air Act ended the tobacco industry's aura of invincibility and showed the coalition that it could win. Whether the coalition can translate one victory into a series of broader legislative actions remains to be seen. The next major goal of the coalition is to limit vending machines, an issue that galvanizes several additional business interests. If that legislation is enacted, it will be clear that tobacco industry influence is waning. If not, the limits of what the

their health threatened by others' poor health habits and did not like the smell of tobacco smoke." Letter dated 20 March 1990.

21 According to a medical society official, smoking is now a policy priority.
coalition can expect from the legislative process may have been reached.
Appendix B
MINNESOTA CASE STUDY

INTRODUCTION
The development of statewide anti-smoking legislation in Minnesota has followed a complicated and unique course. Over the last 16 years, the state has compiled an impressive legislative record. It seems clear, however, that although the initial smoking-control bill passed with little opposition, proponents of smoking controls have had to fight battles of increasing difficulty to achieve successive legislative victories, and that the prospects for additional statewide controls are not especially bright. In fact, as the discussion below indicates, the probability of such controls appears no greater in Minnesota than in other states that have considerably less-mature statewide legislative programs in place.

BACKGROUND
In 1975, Minnesota passed the nation's first comprehensive clean indoor air act and since then has been in the forefront of anti-smoking legislative initiatives. The 1975 law banned smoking in a wide range of public places—including restaurants, retail stores, public facilities and conveyances, worksites, hospitals, and health care facilities—except in designated areas. Ten years later, the Minnesota legislature passed the Omnibus Nonsmoking and Disease Prevention Act, which contained a number of provisions that both strengthened and extended the spirit, if not the letter, of the 1975 law.

Specifically, the 1985 law provided funding for smoking intervention programs for youths, public education and communications campaigns, and special project grants to community health service agencies. In addition, the 1985 law increased the cigarette excise tax from 18 to 23 cents per pack. Perhaps most important, the act provided funds to the State Department of Health to engage in smoking-prevention activities. This is in sharp contrast to the 1975 bill, which provided no funds to the Department of Health to develop rules and, more generally, to implement the provisions of the bill. This lack of funding resulted in an initial set of rules that were described by one observer as simply “not great.”
Since 1985, a series of additional smoking-control bills were signed into law, including bills that prohibited the free distribution of tobacco products to minors; increased the state’s cigarette excise tax to 38 cents per pack; prohibited smoking in day care centers, hospitals, health clinics, and other health care facilities; and required individual state agencies to develop smoking policies.

To smoking-control advocates in other states, the Minnesota anti-smoking legislative record stands as a precedent-setting achievement. Yet in the minds of many Minnesota smoking-control advocates much remains to be done both to strengthen existing legislation and enact new, more restrictive measures.

OVERVIEW OF THE POLITICS OF ANTI-SMOKING LEGISLATION: PAST AND PRESENT

Past

One of the first questions that comes to mind in the case of Minnesota is whether the state's early passage of a comprehensive clean indoor air bill was the result of a grand, well-executed strategy on the part of smoking-control advocates or simply historical accident. The short answer is that while anti-smoking legislators and other advocates should be given credit for mounting an effective legislative effort, the truth of the matter is that the tobacco industry mounted no opposition to the 1975 bill. As one accomplished anti-smoking advocacy group leader noted, "the tobacco companies ignored bill . . . . In 1975 the whole world was swathed in gray haze and the 'buoyant industry,' as they call themselves, saw no bogey man behind the little bill in Minnesota." This view was echoed by the bill's chief architect who wrote:

I also believe that the bill passed in part because it was not taken very seriously by its opponents. They thought it was such a completely ridiculous thing to do that they kept laughing at it all the way to the governor's office. Only after it was signed (unlike Illinois and Maine, where the tobacco lobby has succeeded in obtaining gubernatorial vetoes of similar legislation) did they start complaining about curtailment of rights (Kahn, 1983).

It is also interesting to note that the driving force behind the bill was a single legislator and that, not surprisingly, no formal anti-smoking coalition existed at the time. Several interviewees, however, mentioned that considerable informal support was provided to legislators from organizations that eventually became members of the coalition.
In fact, the state's current coalition, the Minnesota Coalition for a Smoke-Free Society 2000, was not formed until late 1984. At present, the coalition, which has a small full-time staff, comprises representatives from the major voluntary health associations, the Minnesota Medical Association, Blue Cross/Blue Shield of Minnesota, the Association for Non-smokers Rights (ANSR), and other groups.

Additionally, the strategy used by legislators who drafted the bill in 1974 and 1975 may have helped ensure the bill's passage. That is, the proposed legislation was quite broad and perhaps even vague, leaving the details to be worked out in the rulemaking process. As one observer described it, "the 1975 bill was broad in scope and narrow in power." In a sense, the legislation created a framework for implementing increasingly more restrictive smoking controls. In fact, one could argue persuasively that the history of the smoking-control politics in the state since 1975 has been characterized by the struggle to strengthen the original legislation through both the rulemaking process and additional legislation.

**Present**

At this point, proponents of smoking-control legislation may, to a large extent, have become unwitting victims of their own success. Several people interviewed remarked that there is a widely held perception that the job of protecting the public from the hazards of environmental tobacco smoke is all but finished. As one observer succinctly put it, "the issue isn't quite as sexy as it used to be." A second noted bluntly that "people think the problem has been solved."

Furthermore, there appears to be a nagging feeling on the part of some participants in the smoking-control debate that the pace of change has exceeded the tolerance limits of many Minnesotans. One such participant was quite frank about the matter: "things have gone too far, too fast." Moreover, a key member of the coalition reported that, in her view, legislators' perception of the anti-smoking movement has become increasingly negative. She went on to express the fear that in the minds of at least some legislators anti-smoking advocates are simply determined to "make people miserable."

It is possible, however, that these and other individuals close to the smoking-control debate have underestimated the level of popular support for anti-smoking legislation. For instance, the *Minneapolis Star Tribune/KSTP-TV's Minnesota Poll*, a public opinion poll conducted in April 1991, revealed that 60 percent of the respondents favored tightening the state's clean indoor air law. In fact, of those re-
spondents who smoked, 22 percent said that the law should be made more restrictive (Minneapolis Star Tribune, May 6, 1991).

An additional factor complicating anti-smoking advocates' current efforts is that their previous legislative successes have not gone unnoticed by the tobacco industry. Currently in Minnesota, as elsewhere, the tobacco industry maintains a formidable presence. According to one legislator's estimate, the industry directly or indirectly maintains a virtual army of high-priced lobbyists, numbering in excess of 60. Consequently, smoking-control advocates can no longer count on enjoying the fruits of relatively quick and painless legislative victories. The recent battles fought in Minnesota on extending smoking controls in the workplace and placing restrictions on the location of vending machines bear striking similarities to the battles that are currently being waged (and thus far lost) in other states that are far less mature than Minnesota in terms of existing legislation.

Another, though somewhat subtle, consequence of the anti-smoking advocates' success has been a reduced enthusiasm on the part of coalition members and, to a somewhat lesser extent, legislators. One coalition member indicated that the group was essentially directionless and that there was considerable uncertainty regarding what they could and should do next. A second interviewee suggested that some of the department of health's most talented staff members—who had previously devoted large fractions of their time to the smoking issue—relinquished their involvement in the department's smoking-related activities in favor of more "glamorous" pursuits (i.e., AIDS).

The challenge, then, for anti-smoking activists in Minnesota is to keep the issue alive without alienating both legislators and the public at large. With the added burden of strong tobacco industry opposition to additional controls, this is understandably no easy task.

The Role of Key Legislators

From the start, key legislators have played a central role in enacting anti-smoking legislation in Minnesota. As already noted, when the Clean Indoor Air Act was passed in 1975, a formal coalition did not exist. Rather, passage of the act was directly attributable to the efforts of a young legislator who embraced the smoking-control issue and guided the bill through the legislature. Subsequently, legislators continued to assume leadership positions on the issue, and over time they both benefitted from coalition efforts and grappled with an increasingly growing tobacco industry presence. In fact, in many respects the present legislative picture in Minnesota closely resembles
those found in other states with considerably weaker state laws. As one legislator acknowledged, "the rest of the states have caught up, so now Minnesota is not unusual."

To some degree, the relative wealth of legislative leadership can be attributed to the fact that Minnesota has a strong tradition of legislative activism in the areas of health, education, and the environment. Many interviewees cited this progressive tradition as an underlying cause of the state’s stringent anti-smoking laws. In contrast to Arizona and Texas, government intervention in a wide range of areas is viewed as legitimate, if not desirable. One legislator went so far as to say that there is a widely shared philosophy in Minnesota that "it's O.K. for the government to take control of people's lives." Interestingly, this view seems to cross party lines; a legislator who identified himself as a conservative Republican was a strong advocate of the imposition of additional smoking controls.

Although anti-smoking advocates have benefitted from the presence of enthusiastic and capable leaders in both houses, some advocates expressed the view that new blood was needed to invigorate the smoking-control movement. One observer voiced concern that perhaps the most important legislative leaders in both houses have started to lose credibility because they have supported a number of liberal causes in a time of increasing conservatism. The terms "radical" and "do-gooder" were used to describe popular perceptions of two key smoking-control legislators.

The Role of Anti-Smoking Advocates

In examining the role of anti-smoking advocates in Minnesota, one must look beyond the activities of the coalition, for several reasons. First, as mentioned above, the coalition was not established until the end of 1984, nine years after the Minnesota Clean Indoor Air Act was passed. Second, since the early 1970s a group currently known as the Association for Nonsmokers Rights—Minnesota (ANSR) has served as the focal point of the anti-smoking movement. In several respects, ANSR continues to be perceived as the heart and soul of the anti-smoking movement, playing the dual role of functioning as an independent organization while serving as a key member of the coalition. This dual role has apparently led to some confusion on the part of legislators, who frequently referred to ANSR's president as the head of the coalition. Additionally, interviewees generally referred to the two groups interchangeably. This confusion may result, in part, because ANSR's president is viewed as an able and articulate spokesperson for the anti-smoking movement, whereas the coalition's staff
was viewed as being considerably less capable by several individuals interviewed. In any event, this organizational ambiguity is likely to foster communications problems with both legislators and the general public, which, in turn, may detract from smoking-control advocates’ efforts to enact new legislation.

As we observed in several other states, opinions held by coalition members on issues related to strategy and tactics ranged from the generally cautious and conservative positions espoused by representatives of the voluntary health organizations to the more combative styles of individuals aligned with the single-issue advocacy groups. One such individual essentially encapsulated the mentality that pervades many of these groups by noting that, “when you're small and facing a monolith, you can't be reasonable.” Despite these differences, the level of conflict that has existed historically within the Minnesota coalition appears low relative to that of other states, perhaps because of their past successes.

This solidarity has served the coalition well, as key legislators appear to have a positive overall view of both the coalition as a whole and the individual member organizations. For instance, several legislators noted that they rely on the coalition for both technical support and guidance on strategy. In a telling anecdote, one widely respected coalition member recounted an incident in which a legislator asked for her “wish list” of smoking-control measures and was later surprised to find that virtually all of the elements listed appeared in a bill that was introduced shortly thereafter.

Although the coalition has profited in the past from maintaining both a relatively low level of internal conflict and close working relationships with legislators, recent signs of conflict indicate that all is not entirely well within the coalition. Several observers expressed concern over a number of issues that, if allowed to fester, will reduce the coalition’s effectiveness and perhaps even threaten its existence. One interviewee suggested that the coalition’s member organizations “have become more self-centered over time.” In part this may be due to increased competition for charitable donations. According to some interviewees, the voluntary health organizations, in particular, have been reluctant to share their mailing lists with the coalition out of fear that doing so will reduce donations made to their own organizations. One association executive indicated, in a somewhat oblique way, that they would withdraw from the coalition in the event that coalition fundraising efforts became too aggressive.

A second potential source of problems appears to be dissatisfaction with the coalition’s staff. Several representatives of member organi-
zations complained that the staff were simply “worker bees” who were “unimaginative” and lacked “political savvy.” These individuals argued further that the important work was necessarily left to a handful of highly motivated coalition members.

Other interviewees, however, portrayed the coalition’s staff in a more sympathetic light. These individuals noted that, since the coalition relied, in part, on contributions from the major voluntary health associations, they needed to provide a “comfort level” that these more mainstream groups require. That is, to maintain their funding, the coalition’s staff must eschew controversy. In doing so, however, they may hamper their effectiveness and alienate more determined coalition members.

Ironically, despite their apparent limitations, several member organizations have essentially delegated responsibility for all anti-smoking-related activities to the coalition’s staff. The voluntary associations, in particular, have been criticized for the limited interest they have shown in devoting resources—above and beyond those contributed to the coalition—to the issue. One influential coalition member observed that the “voluntary health associations expect the coalition to do all of the work.” And a key legislator indicated that the volunteers’ direct support for smoking-control issues is “close to meaningless.”

In short, there is considerable ambivalence regarding the proper roles for the coalition and its member organizations. On the one hand, there is dissatisfaction over the management and effectiveness of the coalition’s staff. On the other hand, several member organizations have demonstrated an unwillingness to pick up the slack by devoting their own resources, particularly staff, to lobbying and other activities.

The Role of the Medical/Public Health Community

For the most part, the medical/public health community played a minor role in the development of anti-smoking legislation in Minnesota. At least with respect to the department of health, this was because the department was not funded to engage in smoking-prevention and smoking-control activities until 1985. Still, critics maintain that the department could have done more before passage of the 1985 act to implement the 1975 legislation with the resources it had at its command. Moreover, many of the same critics argue that the department is still not doing all that it could in this area.
Organized medicine and the Minnesota Public Health Association have also contributed little to the anti-smoking cause. For instance, it is interesting to note that although individual physicians have played, and continue to play, important roles in initiating and shaping the state’s smoking-control policies, the Minnesota Medical Association is perhaps best known for its quiescence on this issue. Several interviewees noted that the association cannot be counted on for much more than the obligatory letter of support whenever a crucial smoking-control issue is before the legislature and that the association has been unwilling to commit its substantial leadership and lobbying resources to the cause. And none of the interviewees even suggested that the Public Health Association has played any role whatsoever in the smoking-control debate, although it is an affiliate member of the coalition.

The Prospects for Additional Legislation

Most of the interviewees were guardedly optimistic about the prospects for additional statewide legislation (e.g., restrictions on worksite smoking). Virtually all smoking-control advocates acknowledge that state victories will not come easily. In fact, in the last three years, the legislature has defeated bills that would have imposed additional restrictions on workplace smoking, limited the location of vending machines, and mandated fire-safe cigarettes. To avoid similar defeats in the future, the coalition must mend internal conflicts, improve communications with legislators, combat staff apathy, and broaden its base of support to lessen its financial dependence on the voluntary health associations.

Moreover, in light of well-organized and well-financed tobacco industry opposition at the state level, smoking-control advocates are rethinking their legislative strategy. In this regard, an interesting difference exists between Minnesota and the other states studied with respect to the interplay between state legislation and local ordinances governing smoking in public places. In Minnesota, statewide legislation has dominated, largely because of its early origins and the ongoing efforts to expand and strengthen the legislation. As a consequence, attempts to pass local ordinances have been relatively few and far between.

This contrasts with several of the other states studied—in particular New York, Texas, and Arizona—in which local ordinances were responsible for the bulk of smoking controls. Now, however, in the face of mounting industry opposition at the state level, smoking-control advocates are, for the first time, giving thought to developing and
implementing a local strategy, reasoning that new restrictions should first be adopted, or “tested,” at that level before attempts are made at state enactment.

CONCLUSION

In reflecting upon the development of anti-smoking legislation, a key legislator recommended that smoking-control advocates in other states attempt to emulate the Minnesota strategy of passing general initial legislation that could later be strengthened through the rule-making process or through additional legislation. But a careful analysis of the Minnesota experience leads one to question the wisdom of this strategy. To be sure, the initial legislation provided a framework for additional controls. However, given the difficulty inherent in passing virtually any anti-smoking legislation, one could argue that less effort would be expended, overall, in passing an initial comprehensive and stringent bill than in undertaking the arduous process of passing a long series of bills to obtain the same end. Additional support for this position is found in the evidence presented above, which indicated that, at least in the minds of some observers, the initial legislation created the mistaken impression that the task of limiting smoking in public places was all but finished.
Appendix C

FLORIDA CASE STUDY

INTRODUCTION
To tobacco-control advocates, obtaining anti-smoking legislation in Florida has not been an easy task. After enacting weak legislation in 1985 that included a clause preempting stronger local initiatives, the Florida legislature has rejected concerted attempts to strengthen the law in both 1990 and 1991. In both instances, the tobacco industry was able to attach a “smokers’ rights” provision to the law. Although the anti-smoking coalition split over whether to accept the smokers’ rights amendment in return for stronger legislation, the amendment effectively killed both bills.

The failure to enact strong anti-smoking legislation in Florida results from several factors. First, it seems clear that the tobacco lobby remains predominant over anti-smoking advocates in the Florida legislature, at least in its ability to block any stronger anti-smoking legislation. Second, the absence of a strong and unified anti-smoking coalition limited the coalition’s ability to enact its legislation. Finally, the sponsoring legislators were unable to agree among themselves whether the smokers’ rights amendment was an acceptable tradeoff for stronger anti-smoking legislation.

BACKGROUND
Florida enacted its Clean Indoor Air Act in 1985. The act restricts smoking in public places or at public meetings, except in designated smoking areas. This prohibition does not apply when an entire room or hall is used for a private function. Additionally, local governing bodies are prohibited from enacting ordinances more stringent than this legislation (that is, local legislation is preempted by provisions of the Clean Indoor Air Act).

The law requires offices and factories to “make a reasonable effort to develop, implement, and post” a smoking policy—even if the policy says that smoking is allowed throughout the building. But offices and factories are not required to separate smokers from nonsmokers. In addition, restaurants or bars with more than 50 seats can either designate a smoking section or post a sign that reads, “We have no ‘non-smoking’ section.”
Florida prohibits the sale and distribution of tobacco products to minors (under 18). The minimum age for receipt of tobacco samples and for using cigarette vending machines is 18.

In 1985, Florida established a state coalition for the prevention and control of tobacco use, but its annual funding in FY 1990 was only $1500. The coalition includes a representative from the state public health agency and other health professionals. The coalition's activities include public education and information, legislation, developing a state plan for tobacco control, and research and evaluation.

INTERVIEW RESULTS

Even though we spent as much time interviewing in Florida as we did in other states, it was much harder to get a clear picture of the determinants of the legislative outcome than anywhere else. For one thing, there was less consistency among interviewees on several matters, such as the extent of tobacco industry influence, than in other states. For another, the debate had a very ephemeral quality in the difficulty people had in describing its terms and parameters. Paradoxically, there appeared to be plenty of motion by the anti-smoking coalition but little actually happening. As described below, the most likely explanation for this is that the tobacco industry played an insider's game, revealing little, and thus the coalition's activities appeared to be less effective than they really were.

The Legislative Debate

In both 1990 and 1991, the legislature considered amendments to the 1985 Clean Indoor Air Act that would greatly strengthen its provisions. For example, the amendments would require that restaurants seating more than 50 people set aside at least 35 percent of their area for nonsmokers. Also, smoking would not be allowed under any circumstances in hospitals, day care centers, schools, and "common areas" of hotels and motels.

After passing the House (by a 104–9 margin), the 1990 bill went to the Senate where it was amended to prohibit employers from discriminating against smokers by way of disciplinary action. The amended legislation was vetoed by Governor Martinez who said that the bill unfairly discriminated against nonsmokers by prohibiting employers from disciplining workers who violate no-smoking areas. Governor Martinez also objected that the measure would require smoking areas in movie theater lobbies, sports facilities, and airports, even if no
space was available, and regardless of whether the proprietor wished to designate smoking areas.¹

The 1991 bill, without the smokers' rights amendment, also passed the House, but technical amendments (dealing with smoking in prisons and outdoor stadiums) unrelated to the main issues were added in the Senate. When the bill returned to the House, it was further amended to include similar nondiscrimination provisions as in the amended 1990 legislation. As a result, anti-smoking advocates killed the bill when it returned to the Senate.

According to anti-smoking advocates, the addition of technical amendments in the Senate was part of the tobacco industry's coordinated strategy to delay action on the bill and then overwhelm the anti-smoking coalition during the session's closing hours. Evidently, the tobacco lobbyists had the agreement and support of the leadership, along with the votes to implement this strategy.

In both the 1990 and 1991 sessions, the legislative debate on anti-smoking legislation can be characterized as being virtually no debate at all. In several interviews conducted before the outcome of the 1991 legislation, legislators were unable to explain what the important issues on the bill were because no announced opposition had emerged.² That is, there was no debate on the substance of anti-smoking legislation. For most of the 1991 session, the tobacco lobby was notable for its public absence.³ As in Illinois, there was also no real debate over the scientific evidence. Despite tobacco industry attempts to discount the effects of the scientific evidence, most legislators seemed to accept the proposition that cigarette smoking is harmful, and the mounting evidence of the harm from secondhand smoke further undermined tobacco industry claims. Nor did the costs of regulation and enforcement appear to be an important issue.

To the extent that a debate ensued, it was dominated generally by personal freedoms arguments and by the nondiscrimination (smokers' rights) language specifically. These arguments appealed directly to

¹Veto message, 3 July 1990.
²We were unable to arrange interviews with legislators identified as sympathetic to the tobacco industry.
³In one notable departure, the tobacco industry arranged for pro-industry experts to testify before a House committee that the scientific evidence did not support finding harm from cigarette smoking, and that the "sick building syndrome" was the real culprit, not cigarette smoke. Several observers noted that the presentation backfired because it lacked credibility and encouraged wavering legislators to support the legislation.
minority legislators (particularly blacks)\textsuperscript{4} and to civil libertarians who viewed this as a civil liberties issue. As one key anti-smoking legislator stated, the tobacco industry strategy was "to unite white liberals and blacks on personal freedoms." The attempt by the anti-smoking coalition to frame the legislation as a public health issue rather than a civil liberties issue failed. Once the debate shifted from public health, which favored the anti-smoking coalition, to personal freedoms, an unusual coalition of pro-tobacco and pro-civil liberties legislators emerged to support the tobacco industry position.\textsuperscript{5}

It thus appears that the tobacco lobby and its legislative supporters played a classic insider's game, taking advantage of chaotic end-of-session procedural motions that led to unacceptable amendments. This suggests that the tobacco influence in Florida is tied to key legislators and may not be pervasive throughout the legislature.\textsuperscript{6}

In Florida, key legislators, especially those in leadership positions, virtually control the flow of legislation. As it turned out, the tobacco industry was able to achieve its goals through private access to key legislators without having to commit itself to a public position. According to one key observer, the tobacco industry relied on "power politics and money, and a deliberate strategy not to raise issues." This shrewd strategy not only achieved positive results for the industry,\textsuperscript{7} it also saved its legislative supporters from taking public positions that might not be popular with constituents. In retrospect, it appears that the tobacco industry was confident that it retained sufficient influence in the Senate to delay a vote and in the House to at-

\textsuperscript{4}In Florida, as in many other states, the tobacco industry has contributed money to minority community programs. Despite a certain backlash to cigarette marketing practices directed to minorities, some minority legislators have been receptive to tobacco industry arguments.

\textsuperscript{5}According to several observers, legislators from North Florida tend to be more anti-government and thus would be more receptive generally to tobacco industry arguments against governmental interference. At one time, North Florida had a substantial tobacco economy, though it is now only a residual factor. Northern Florida legislators apparently hold the balance of power in the legislature.

\textsuperscript{6}In Florida, the Speaker of the House and President of the Senate rotate every two years. Thus, the conclusion that the tobacco lobby influence is tied to key legislators is somewhat uncertain. It could be that current influence is closely identified with a few key individuals. But if the influence remains under the new leadership, it suggests that the influence is more pervasive than anti-smoking coalition members suggest. Indeed, one anti-smoking legislator stated that it was simplistic to view tobacco industry influence in such narrow terms.

\textsuperscript{7}This represents a win-win strategy for the tobacco industry. Either a smokers' rights amendment is enacted or the bill is killed. Either result appears to be acceptable to the tobacco industry, though we are unable to determine whether the industry is indifferent between these two alternatives.
tach a nondiscrimination amendment late in the session. Since this amendment required concurrence in the Senate, it meant that the bill was effectively killed.

According to several observers, the Florida legislative debate has been generally nonpartisan. For example, Republican Governor Martinez vetoed the 1990 legislation that included anti-discrimination language over the apparent objections of the tobacco industry. In a strange twist, the tobacco industry may actually have greater access to the new Democratic Governor Chiles because their chief lobbyist has close ties to the Chiles Administration. More important, the tobacco industry in Florida, as in New York, appears to rely heavily on lobbyists with numerous important clients rather than those just representing tobacco interests. This strategy appears to provide greater access and leverage than would be available to single-industry lobbyists. It also suggests that the tobacco industry recognizes that it can no longer dominate the legislature on its own.

Finally, it appears as though anti-smoking legislation in Florida is not closely tied to other public health legislation. That is, the enactment of anti-smoking legislation in Florida is independent of and treated differently from other public health legislation such as seatbelt or drunk driving laws. According to one observer, public health legislation is considered separately, and “There is no carry-over [to anti-smoking legislation] from other public health legislation.”

The Role of the Anti-Smoking Coalition

Much of the initial impetus for anti-smoking legislation in Florida emanated from committed legislators and individual voluntary associations. As late as the beginning of 1990, there was no active anti-smoking coalition, although individual members of what eventually became the anti-smoking coalition lobbied for stronger anti-smoking legislation. No single lobbyist represented the coalition's interests or coordinated strategy until late in the 1990 session, when the voluntary associations hired an experienced lobbyist to coordinate their efforts.

The absence of a coordinated strategy left the coalition unprepared to respond to legislative maneuvers initiated by tobacco lobbyists and

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8Because representatives from organized Florida business groups, particularly Associated Industries, refused several interview requests, it is difficult to determine what role such groups play in anti-smoking legislation. It does not appear that business groups per se made a major difference in the legislative outcome.
supporters. As a result, when the 1990 legislation was amended to include an anti-discrimination provision, the coalition split, rendering its efforts fragmented and less effective. Most members were willing to accept the anti-discrimination language as a compromise tradeoff for stronger legislation, but others argued that the bill should be vetoed because of the smokers' rights amendment. Thus, the coalition was unable to present a unified position to the governor on whether the bill should be vetoed. In the end, Governor Martinez vetoed the bill.

By the 1991 session, however, the coalition had begun an extensive grass-roots campaign, including several media events and newspaper editorials, in support of stronger legislation. The 1991 coalition appeared to have adopted a more coordinated and unified state-level strategy under the leadership of two sophisticated and experienced lobbyists. Even though no legislation was enacted, the coalition held together in its opposition to the smokers' rights amendment and was able to generate considerable media pressure to enact stronger anti-smoking legislation.

In Florida, we had the unusual circumstance of observing a new coalition in a state that had been debating anti-smoking legislation for several years. Although most observers credit the coalition with raising grass-roots attention and enlarging the base of support, the legislative outcome suggests potential deficiencies in coalition efforts. Although the coalition now has an active grass-roots network, it is not pushing to challenge the preemption provision or to enact local ordinances. According to a key coalition strategist, the coalition finds it easier to work at the state level.9 Nor has it done much to involve the politically active senior citizens' groups.

Before the final vote on the 1991 legislation, coalition representatives were confident that the anti-discrimination amendments could be defeated in both houses and that stronger anti-smoking legislation would be enacted.10 But the coalition was apparently unprepared for

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9 Although there is strong anti-smoking legislation in South Florida, particularly in Broward County (Miami), there does not appear to be a major push for localities to regulate smoking. A local Miami group, Group Against Smoking Pollution (GASP), is the primary proponent of legislation to eliminate the preemption provision. GASP is not currently a coalition member.

10 Not surprisingly, tobacco industry lobbyists were equally confident that they could kill stronger legislation by attaching a smokers' rights amendment. One tobacco industry lobbyist was quoted in The Tallahassee Democrat as saying that "It's [the anti-smoking legislation] going to run out of momentum at the appropriate moment." Despite repeated requests, Florida representatives of the tobacco industry refused to be interviewed for this study.
the tobacco industry’s ability to act effectively under the end-of-session chaos and was unable to prevent a vote in favor of the anti-discrimination amendment.

Initially, anti-smoking advocates relied on sporadic media attention rather than coordinated media strategies. During the 1991 session, however, the anti-smoking coalition began to generate considerable media attention in several areas across the state. After the 1991 session, for example, The Miami Herald ran a blistering editorial against legislators in the Miami area who sponsored or voted for the anti-discrimination amendment.\(^{11}\) Thus, despite a more concentrated media and grass-roots effort, the coalition is not yet strong enough to compete politically with the tobacco industry.

**The Role of Public Opinion**

Although a Gallup poll commissioned by the American Cancer Society in 1990 showed that a substantial number of Floridians favor limitations on smoking in public places, most observers suggested that there was very little overt public pressure on the legislature to enact such limits. Most legislators stated that they received very little constituent pressure to enact anti-smoking legislation, except for the direct lobbying by the anti-smoking coalition. In Florida, underlying changes in societal attitudes toward smoking in public places have not yet been a sufficient motivator for the legislature to take stronger action.

Most observers agreed generally that public opinion favored restrictions and that anti-smoking sentiment was growing.\(^{12}\) Nevertheless, years of strong and effective lobbying provided the tobacco industry with sufficient strength to block unfavorable legislation by including a nondiscrimination provision. In Florida, the political debate does not appear to be between an industry in political decline (the tobacco industry) and a coalition with emerging power (the anti-smoking coalition). As one observer put it, “The tobacco industry had too much money, too many political ties, and was willing to play political hardball to achieve its goals.”


\(^{12}\)One sponsor of anti-smoking legislation agreed that public opinion matters but that it was not a given that public opinion in Florida supports smoking restrictions. In any event, this legislator argued that the tobacco industry was better organized than the coalition.
In fact, the enactment of a nondiscrimination provision appears to have been a major tobacco industry goal in Florida.\textsuperscript{13} It appears that the tobacco industry was even willing to accept stronger anti-smoking language in return for nondiscrimination language. Recent success in New Jersey and Arizona, as well as Florida, suggests that the personal freedoms argument on which the nondiscrimination provision rests is beginning to resonate among state legislators, despite public opinion favoring smoking restrictions. Having essentially lost on the public health issues, this strategy is a clear attempt to frame the issue in a way that makes it particularly difficult for civil liberties advocates and minority legislators to oppose. In certain states, particularly New York, however, the findings on the harm from secondhand smoke have blunted the tobacco industry’s personal freedoms arguments.

In a state with a large elderly population, senior citizens’ groups might be expected to play an important role in anti-smoking legislation. This role, however, might cut two ways. Some elderly may have moved to Florida for respiratory reasons and would thus support smoking restrictions. Others may not care whether anyone smokes. There appears to be little evidence to support either view. Right now, senior citizens’ groups do not appear to be an important factor one way or the other. It is nevertheless interesting to note that no senior citizens’ groups are listed as supporters of the anti-smoking coalition, and the anti-smoking coalition has apparently made little effort to enlist them.

**The Role of the Public Health Community**

The Florida Medical Association (FMA) is an active member of the anti-smoking coalition and has actively lobbied on behalf of stronger anti-smoking legislation. Even though smoking has not been a priority issue for the FMA, the FMA has worked closely with coalition lobbyists and anti-smoking legislators, particularly to enact the 1991 legislation. Individual members also regularly testified and contacted key legislators.

Surprisingly, the Florida Public Health Association (FPHA) has not been an active participant in the anti-smoking legislative debate. Although the FPHA wrote letters to support anti-smoking legislation, they did not testify or provide data on its behalf. In general, the

\textsuperscript{13}From what we have seen in our six-state study, the enactment of antidiscrimination provisions appears to be a major tobacco industry goal nationally.
FPHA is not politically involved and has no independent tobacco-use prevention and education activities.

The Florida Department of Health and Rehabilitative Services (DHRS) has generally supported anti-smoking legislation but has not actively pushed for enactment until recently. Under the Martinez Administration, DHRS was neutral on anti-smoking legislation and provided no direct analysis for the legislature. Indeed, DHRS encouraged Governor Martinez to sign the 1990 bill despite the smokers’ rights language because it would not supersede existing law or enforcement responsibilities. DHRS expects to play a more active role in the Chiles Administration and has made smoking a priority issue.

CONCLUSION

In some ways, the results of the 1990 and 1991 legislative maneuvers on anti-smoking legislation simply perpetuate the status quo. The 1985 law remains intact, and the anti-smoking coalition will continue to press for stronger legislation. To a certain extent, however, there appears to have been a subtle shift in the power balance between the tobacco industry and the coalition. Far from being on the decline in Florida, the tobacco industry was not only able to block the stronger legislation, it also received a favorable vote in the House on the nondiscrimination amendment. As a result, the coalition will need to develop a strategy that returns the debate to public health issues to avoid future losses.

14Legislative staff have worked with DHRS staff, however.
Appendix D

ILLINOIS CASE STUDY

INTRODUCTION

In June 1989, Illinois passed controversial legislation prohibiting smoking in most public places. The original legislation was heavily amended, representing a compromise between the tobacco industry and an organized anti-smoking coalition. Because the final proposal lacked enforcement provisions, preempted potentially stronger local ordinances, and included vague language concerning workplace smoking requirements, its original sponsor removed his support from the bill. The legislation led to a split among the anti-smoking coalition, with a minority opposed to its passage.

Legislative leadership and an organized tobacco-control coalition appear to have been the primary determinants of the Illinois legislative outcome. Without the coalition and its ability to organize the anti-smoking forces and key legislators to draft a compromise bill, it is unlikely that anti-smoking legislation would have been enacted.

BACKGROUND

In 1975, Illinois enacted strong anti-smoking legislation that did not survive a veto by Governor Walker. No other statewide anti-smoking legislation was enacted until the passage of the Illinois Clean Indoor Air Act of 1989 (effective 1 July 1990). Until then, only 24 (including Chicago) of 1279 Illinois municipalities had enacted ordinances restricting smoking in public places.

Under the 1989 Clean Indoor Air Act, smoking is restricted in arts/cultural facilities, elevators, gymnasiums/arenas, health facilities, meeting places, public places, public transit, restaurants, retail/grocery stores, and schools. The law does not restrict smoking in bars, bowling alleys, hotel rooms, factories, warehouses, rooms rented for private use, and privately enclosed offices occupied by smokers. Perhaps most significantly, the law reverses the tradition of creating nonsmoking areas by requiring no smoking at all unless a smoking area is set up. The legislation allows business owners to designate a “reasonable portion” of a room as a smoking area, but the size of this “reasonable portion” is not defined.
In a concession to the tobacco industry, the act preempts local communities from enacting policies more stringent than those of the state law, unless those policies were in place before October 1, 1989. Also, the law includes an ambiguous provision prohibiting discrimination on the basis of smoking behavior.

In addition to the Clean Indoor Air Act, Illinois established in 1978 a Tobacco Control Prevention Plan, but the plan has no annual funding.¹ The plan includes a representative from the health department as well as other health professionals. The plan's activities include: promoting a Smoke-Free High School Class of 2000; public education and information; professional education; smoking cessation programs, especially for pregnant women; and developing a state plan for tobacco control. So far, the state plan appears to have focused on tobacco-use prevention and cessation.

Currently in Illinois, the minimum age for using cigarettes and smokeless tobacco is 18, but no laws restrict sales of tobacco products in vending machines. Since 1988, Illinois has restricted the distribution of tobacco-product samples to minors, and in 1990, Illinois enacted a law banning all smoking in schools. In 1990, the Illinois legislature debated, but did not enact, laws restricting tobacco-products advertising, tobacco sales to minors, and access to cigarette vending machines for minors.

**INTERVIEW RESULTS**

Passions remain intense among participants of the legislative debate. Although there are signs that a healing process has begun, the split in the coalition over whether to accept the Clean Indoor Air Act with the preemption provision nearly undermined the coalition's negotiating position. Despite the split, however, the act does represent a change in the legislature's statement of policy and perhaps a change in the terms of the debate.

¹Nevertheless, the Illinois State Health Department maintains an active tobacco education and prevention campaign. For example, tobacco-use prevention and cessation is an integral aspect of the Illinois Cancer Control Plan prepared by the Illinois Department of Public Health in 1989. Since 1988, the department has employed a tobacco coordinator to oversee the department's tobacco-use prevention activities.
The Legislative Debate

By the time the Clean Indoor Air Act was enacted, there was actually very little debate on the broad philosophical and epidemiological aspects of smoking limitations. For the most part, legislators were willing to accept whatever compromise was reached by the lobbyists.\(^2\) Even though the evidence of harm caused by passive smoke tended to blunt the industry's personal freedoms arguments, it appears as though years of considering tobacco-control legislation had inured the legislators to further debate on the merits.\(^3\) Essentially, as one lobbyist put it, most veteran legislators had already taken a position, so the medical aspects made little overt difference, aside from the ways in which the accumulated medical evidence helps shape underlying public opinion. In this sense, the legislation reflects more the ultimate evolution of accumulated events rather than the outcome of a specific debate.

What little legislative debate actually occurred focused on the costs of implementing anti-smoking laws. Hearings were held on the Clean Indoor Air Act, but they focused on implementation problems (that is, costs and the potential regulatory burden) faced by other states. An Illinois Department of Public Health survey of other states effectively countered industry arguments that the legislation would be too costly to implement. As part of the compromise, however, the tobacco industry was able to omit any regulatory enforcement mechanism.\(^4\)

As a result, it is somewhat difficult to determine which arguments were persuasive and which strategies were most effective. Probably the most successful tobacco industry argument to a relatively conservative state legislature was governmental interference in private behavior. Tobacco industry supporters, such as restaurateurs and vending machine operators, along with the Illinois Chamber of Commerce, stressed this issue. Even individual members of the Illinois State Medical Society were reportedly reluctant to have the government de-

\(^2\)An important exception was then Senator and now Lieutenant Governor Kustra who stated that the compromise bill was not strong enough. It will be interesting to see if he introduces stronger legislation on behalf of the new governor.

\(^3\)This is not to suggest that philosophical disputes played no role in the legislative outcome. For example, the Illinois Chamber of Commerce opposed the bill as a governmental intrusion into private economic arrangements. But it does suggest that these disputes were relegated to a subordinate role after some 15 years of debate.

\(^4\)It may well be, however, that anti-smoking laws are inevitably self-enforcing, because it is unlikely that states will enact strong enforcement mechanisms. States are unlikely to bear the costs of employing police to enforce no-smoking laws or impose those costs on business. Either the people will adhere to these laws or they will not. This hypothesis should be examined in future research.
termine smoking behavior, despite the attendant health risks.\textsuperscript{5} But the emerging evidence of the health risks from secondhand smoke substantially undermined this argument and provided a strong rationale for governmental intervention. Just as important, the tobacco industry had a difficult time refuting evidence of the harm from secondhand smoke.\textsuperscript{6}

Except for evidence on secondhand smoke, most observers agree that the overall public health environment played only a minor role in the debate. And most observers saw no connection between smoking and other public health legislation (such as seatbelt laws). According to several observers, tobacco legislation follows its own legislative track because it affects such a large and powerful industry. Moreover, the debate does not appear to have been partisan, although coalition members stated that the obstacles were primarily among Republicans in the Senate. Many downstate Democrats, for instance, opposed the legislation as interfering with local prerogatives, but Governor Thompson, a Republican, supported the measure.

The Role of the Anti-Smoking Coalition

Almost everyone, including the tobacco lobbyists, credited the formation of a broad-based anti-smoking coalition and concomitant hiring of sophisticated lobbyists with effectively translating public sentiment against smoking into an acceptable legislative compromise. As one close observer put it, “The coalition put the issue on the state agenda.” Before forming the Illinois Interagency Council for a Tobacco-Free Society, a formal coalition of the voluntary associations (composed of the American Cancer Society, the American Heart Association, and the American Lung Association), physician organizations, and public health groups, there was no coordinated, well-defined strategy for pursuing the legislation, and only limited resources were allocated for enactment. Each of the voluntary associations instead relied on a grass-roots effort, which did not sufficiently threaten the opposition.

\textsuperscript{5}In general, business groups were not active in this debate, except for those industry groups directly affected by smoking limitations, primarily those already represented by the tobacco industry lobbyists. Tobacco industry arguments that business would bear a cost burden if this legislation were enacted led to the weak enforcement provisions already mentioned. Such claims of business loss have not been substantiated through empirical studies.

\textsuperscript{6}For example, one tobacco lobbyist argued that environmental harm comes from sick buildings not cigarette smoke (as quoted in Illinois Medicine, 17 February 1989, p. 11), a claim that received little credence among legislators.
The failure of this strategy led to the formation of the coalition and eventual hiring of experienced lobbyists as a countervailing lobby to the tobacco industry.\(^7\) The coalition then devised a coordinated strategy that included grass-roots activities, a schedule for contacting legislators, and a time-line strategy for enacting the bill. By generating calls and letters to the legislative leadership, the coalition was able to pressure the legislature in a way that forced the tobacco industry to compromise. In other words, the coalition created the impression of broad support, which the legislature could no longer ignore. Most observers agree that without the coalition, the diffuse anti-smoking support would not have been sufficient to counter the tobacco lobby. According to one key legislator, there was very little constituent pressure to enact the Clean Indoor Air Act, and there would have been “no legislation in the absence of the coalition.”

Nevertheless, the tobacco industry’s ability to generate legislative support enabled it to insist on three controversial measures in the final bill: preemption of local ordinances (except for those already enacted), nondiscrimination on the basis of smoking behavior, and no enforcement mechanism. Tobacco industry lobbyists were only willing to accept a bill that included statewide preemption of local ordinances. After a prolonged internal debate, a majority of the coalition, under prodding from its primary legislative supporters, agreed to these provisions as a compromise. A minority of the coalition refused to accept the compromise and split from the coalition.

What ultimately moved the majority of the tobacco-control coalition to accept the compromise was the industry concession that existing ordinances would be grandfathered and the reality that few additional gains could be expected in key downstate municipalities. Although the coalition attempted to enact local ordinances to put pressure on the tobacco industry at the grass-roots level, they had little success in downstate municipalities. The effort, however, was sufficiently successful, or at least costly to the tobacco industry, to “encourage” compromise legislation. Supporters of the compromise argue that they conceded less through preemption than they gained through the enactment of statewide legislation. In this sense, they argue, the Illinois preemption was a red herring because they abandoned something they could not have won in any event.

Supporters of the compromise also argued that the bill would shift the burden from nonsmokers to smokers, a reversal of current standards.

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\(^7\)Some coalition members stated that the bill “needed a sophisticated lobbyist to be enacted.”
That is, a proprietor must provide a smoking area rather than a non-smoking area if requested. As a result, the compromise legislation would impose at least some smoking limitations throughout the state. However, some members of the anti-smoking coalition expressed concern that the ambiguous nondiscrimination provision could be used by smokers to undermine the legislative intent of placing the burden on the smoker.

Given the alternative of accepting these provisions or having no bill, the coalition accepted the compromise offered. Even so, the acceptance of the preemption and nondiscrimination clauses remains a divisive factor within the anti-smoking coalition. Those groups opposed to the compromise viewed preemption as a fatal weakness and also argued that stronger negotiating could have at least eliminated the nondiscrimination language. The opponents within the coalition preferred no bill to one containing preemption and viewed the compromise legislation as a weak bill on its merits.

It is clear that the formation of the coalition is a key factor in explaining the legislative outcome. Whether the outcome would have been different had the compromise been rejected, as urged by the minority position, is less important than the coalition's general ability to influence the legislative outcome. Most observers, however, argue that stronger legislation could not have been enacted in 1989, though stronger legislation might have been possible in the next legislative session (two years later). Indeed, a key legislator argued that "Realistically, we could not come back if the coalition collapsed. The tobacco industry would be given the upper hand."

**The Role of Key Legislators**

In addition to the coalition, key legislative support was crucial in securing the bill that was passed, especially in the House. Key legislators were also crucial to the tobacco industry in blocking stronger legislation in the Senate. Much of the impetus for the Clean Indoor Air Act emanated from one or two key legislators in the House who continued to introduce strong anti-smoking legislation despite obstacles in the Senate. These legislators were instrumental in pushing the legislation and, more important, in convincing the anti-smoking coalition that the final bill was the best they could get at that time. Stronger legislation, they argued, could have passed the House, which in 1988 banned smoking on the House floor, but not the Senate.

According to several observers, two key "personnel" shifts facilitated the final compromise. One was a change in the House bill's sponsor,
and the other was a change in the primary tobacco industry lobbyist. Both changes resulted in a greater willingness to compromise, as the extremes were neutralized.

Although tobacco-industry strength in Illinois appears to be waning, the industry's formidable lobbying skills, coupled with legislative unwillingness to dictate to private industry, still provided the tobacco industry with considerable legislative power to block more restrictive anti-smoking legislation. The tobacco industry retained enough support among the Senate leadership, even though no one legislator took the lead in opposing the Clean Indoor Air Act, to block legislation the industry opposed.

The Role of Public Opinion

Public opinion and perceptions of public opinion underlie all legislative activity. Neither side commissioned specific public opinion polls to measure public support within Illinois for anti-smoking legislation, and neither side engaged in a media campaign to enlist public support. To a certain extent, this became an insider's game played by sophisticated lobbyists on both sides. Even some anti-smoking legislators agreed that there was little overt constituent pressure to enact anti-smoking legislation. Nevertheless, both sides agreed generally that public opinion favored restrictions on smoking in public places and that anti-smoking sentiment was growing. As one anti-smoking advocate put it, "People know the truth on tobacco." And an observer sympathetic to the tobacco industry concurred, saying, "It is clear that the voluntary demand for non-smoking areas has increased."

There does, however, appear to be a certain paradox in how the presumed public opinion trends appear to have shaped the legislative outcome. One trend is that each year the anti-smoking forces become that much stronger as public opinion against smoking increases. Another concomitant trend is that each year the tobacco lobby

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8 It is instructive that in a strong home-rule state, the tobacco industry retains sufficient legislative clout to insist on a provision that preempts subsequent local ordinances. This suggests that the tobacco lobby believes that it has more strength at the statewide level than at local levels. Indeed, several coalition members stated that the Senate leadership would not do anything the tobacco lobby rejected. As one key anti-smoking legislator stated, "The tobacco industry feels threatened, but it still has clout—especially money."

9 If public opinion is measured by the ability to enact local ordinances, the anti-smoking effort was not succeeding in most Illinois municipalities. National polls, however, show widespread public support for restrictions on smoking in public places. A 1985 Gallup poll, for instance, showed that 87 percent of the public believes in total smoking bans or restrictions to designated areas.
strength erodes. Despite these trends, the tobacco lobby strength in Illinois, through years of strong and effective lobbying, was deemed sufficient to block any legislation it opposed. The question for the tobacco industry was how long it could contain the anti-smoking trends that would eventually force even its long-time supporters to abdicate and what compromises it could extract from a less powerful opposition. One observer close to the tobacco industry put it bluntly: “Each subsequent year [the coalition] could have gotten more. Take what you can control. Legislators had to have something to take to the voters.”

It thus seems clear that the tobacco industry accepted a compromise bill to forestall stronger legislative action in the future. This does not mean that the tobacco industry has acceded to the anti-smoking advocates. Quite the contrary. During the 1991 legislative session, the tobacco industry successfully enacted a general nondiscrimination provision that would limit an employer’s ability to base employment decisions on the private use of a legal product (such as cigarettes). According to several observers, the bill was pushed by an unusual alliance of labor and tobacco interests. Anti-smoking advocates were apparently late in opposing the bill.

For the majority of the anti-smoking coalition, however, getting something passed was primary, hence the coalition was also willing to compromise. But the minority in the coalition opposed to the compromise argued strongly that waiting until the next session would produce stronger legislation, because they viewed anti-smoking trends as inexorable.

The fact is that the 1989 legislation is weaker than the 1975 bill vetoed by then Governor Walker. In the 1970s, the tobacco lobby could not stop the legislation, but they were able to induce a veto from the governor. During the intervening period before the passage of the 1989 legislation, both sides got stronger in the legislature, but public sentiment turned more strongly against smoking, inducing the compromise legislative solution. Does this indicate that on balance the anti-smoking forces were actually weaker in 1989 than they were in 1975, despite supposed greater public antipathy to public smoking? There is no clear answer to this question, but it does suggest that the anti-smoking movement in Illinois, while growing and gaining momentum, was simply not sufficiently powerful to overcome the more established tobacco industry. The anti-smoking coalition in Illinois needed more time to generate grass-roots support and develop more effective legislative strategies.
The Role of the Medical/Public Health Community

Like any other lobbying group with a variety of legislative concerns, the Illinois State Medical Association chooses which battles to fight and which priorities to emphasize. The question, therefore, was not whether the association would support anti-smoking legislation (since 1979, the association had been a strong supporter of such legislation), but how actively it would support the Clean Indoor Air Act. Despite this strong support, the association was not actively involved until late in the process and did not make it one of the association's higher legislative priorities.\textsuperscript{10} What may be more important, however, is that the medical association's presence added credibility to the coalition, legitimated the secondhand smoke arguments, and thus helped deflect tobacco-industry arguments. Medical association opposition to the bill would have been fatal; its support, however, facilitated passage.

The Illinois Public Health Association (IPHA) was an active participant in the anti-smoking coalition, particularly in generating local support and in working with local health departments. As part of the coalition, the IPHA actively lobbied to enact the bill.

The Role of the Executive Branch

For the most part, Governor James R. Thompson supported the legislation but was not an active participant in the debate. In his message announcing the bill's signing, however, he mentioned the compromise nature of the legislation and indicated his approval as an important first step. He added that "I strongly urge the General Assembly to consider legislation . . . that will further improve the state commitment to protecting individuals from second-hand smoke."\textsuperscript{11} Even if the governor's office had been more involved, most agreed, the legislative outcome would not have been much different.

After 1985, the Illinois Department of Public Health (IDPH) took a position favoring the legislation but did not take an active role with the coalition in pressing the legislature for a stronger bill. According to IDPH officials, the department was unhappy with the preemption

\textsuperscript{10} Many individual physicians were actively involved at both the state and local levels. In fact, one legislative leader stated that calls and letters from individual physicians were more important than the organized medical/public health communities. Also, the Illinois Medical Society does not have a public tobacco-use prevention and education campaign, nor does it work formally with the Illinois Department of Public Health on tobacco-use prevention and education.

\textsuperscript{11} Governor's message, 9 January 1990.
provision but supported the legislation as the best that could be achieved. Just as important, the IDPH provided research and educational support to the legislature.

CONCLUSION

The Illinois Clean Indoor Air Act of 1989 remains controversial. To its supporters, the bill represents a first step toward the reduction of cigarette consumption. To its detractors, it is either an intrusion into people's right to control their personal behavior or a weak bill designed to mollify the tobacco industry. But because the legislation leaves many questions unanswered, and the coalition is healing its split, future legislative battles can be expected. The outcome of these battles is, of course, uncertain, although the tobacco industry's ability to enact a nondiscrimination provision in 1991 suggests that further anti-smoking legislative gains may be difficult to achieve.
Appendix E
ARIZONA CASE STUDY

INTRODUCTION
In several important respects, the historical development and current state of smoking-control legislation in Arizona closely resemble characteristics of the Texas case study. For instance, although Arizona was, in 1973, the first state to pass a law that restricted smoking in a variety of public places to designated areas, no subsequent statewide legislation of significance has been passed, and the level of statewide legislation remains—as in Texas—“basic,” according to ratings published by Tobacco-Free America (1990).

Another important similarity between the two states lies in the widespread adoption of local smoking-control ordinances. In Arizona, such ordinances have been passed in 14 cities and counties, including the major municipalities of Phoenix, Tucson, Flagstaff, and Yuma. The coverage and penalties associated with the ordinances vary, but most require that nonsmoking areas be designated in enclosed public areas and enclosed common areas at worksites (e.g., conference rooms and restrooms) (Arizona Department of Health Services, 1990). Using census data, we estimate that approximately 90 percent of the state’s population is covered by one or more smoking-control ordinances.

Finally, and perhaps most important, many residents of the two states view governmental initiatives with considerable suspicion, and the degree of suspicion generally increases with the level of government. In fact, in this regard Arizonans hold even more extreme views than Texans. Several interviewees illustrated this point, noting that Arizona was the last state to initiate a Medicaid program and, moreover, does not recognize daylight savings time. In addition, phrases such as “big brotherism,” “last frontier,” “libertarian attitude,” “rugged individualism,” and “home rule is sacred in this state” frequently emerged as the interviewees attempted to explain the absence of strong statewide legislation. In short, this attitude stacks the deck against passing statewide anti-smoking legislation.

BACKGROUND
As indicated above, statewide law governing smoking in public places is minimal in Arizona. In 1973, the legislature passed a law that
prohibits smoking in elevators, public recreational facilities, buses, health care institutions, public waiting rooms, and schools, except in designated areas. Subsequent legislation prohibits smoking in state buildings in the event that a formal complaint is received and no reasonable accommodation is reached. This legislation also prohibits termination, discrimination, or disciplinary action against any employee who lodges a complaint (Arizona Department of Health Services, 1990).

Arizona has also passed legislation that prohibits the sale or distribution of tobacco products to minors and requires public schools to conduct educational programs on the health hazards associated with tobacco use.

OVERVIEW OF THE POLITICS OF ANTI-SMOKING LEGISLATION

In Arizona, as elsewhere, tobacco industry opposition to statewide tobacco legislation is strong, well-organized, and amply financed. It is interesting, however, that the tobacco industry has assumed a somewhat low public profile on the issue, relying instead on considerable behind-the-scenes maneuvering to influence key legislators. Along these lines, anti-smoking forces expressed considerable concern over the fact that one of the key industry lobbyists, Robert Usdane, is the former president of the state Senate. Despite periodic public displays of opposition to smoking-control legislation, the industry was referred to time and time again as the “invisible enemy.”

Whatever their particular tactics, one could argue that the tobacco industry has proved quite successful in blocking legislation perceived to be detrimental to its interests. In part, their success can be attributed to the fact that they have “ridden the western spirit horse,” in the words of one anti-smoking advocate, and have successfully framed the debate in terms of a rights issue rather than a health issue.

In contrast to the tobacco industry, supporters of strong statewide legislation have thus far failed to establish a potent and cohesive coalition. The state’s coalition has suffered from substantial internal strife, which, as one would expect, has significantly reduced its effectiveness. This, together with relatively weak legislative leadership, has served to dim near-term prospects for the passage of additional statewide anti-smoking legislation.
The Fractious Coalition

The Coalition for a Tobacco-Free Arizona was formed in mid-1990\textsuperscript{1} in response to the publication of an Arizona Department of Health Services (DHS) report containing the recommendations of a DHS advisory committee on tobacco-use prevention and control. The recommendations made in the report covered legislation/policy, education/prevention, cessation/treatment, and general implementation and management. The report also made several individual recommendations, including a state law requiring that vendors of tobacco products be licensed by the Arizona Department of Revenue.

The purpose of the coalition is to coordinate activities aimed at implementing the advisory committee’s recommendations. Currently, the coalition is composed of representatives from the major voluntary health associations, the Arizona Department of Health Services’ Office of Health Promotion and Education, the Arizona Medical Association, Blue Cross/Blue Shield, the Governor’s Office of Drug Policy, and several anti-smoking advocacy groups. Member organizations contribute staff time for conducting coalition-sponsored activities.

Although a mere year old, fundamental disagreement regarding philosophy and strategy has already wrecked the coalition, resulting in the withdrawal of a key coalition faction and in its diminished credibility among key legislators. The origins of the conflict are complex but essentially involve differences in three areas. First and foremost, a clear division exists with respect to whether smoking should be regulated at the state or local level. The majority of the coalition’s members believe that smoking-control legislation should primarily be the responsibility of the state—although, to be sure, localities should be left with the prerogative of passing ordinances that go beyond the state legislation. On the other hand, a small but vocal minority faction—the same faction that seceded from the coalition—maintains that smoking regulation belongs, with one exception, within the jurisdiction of local governments. The exception involves regulations that can only be passed at the state level—for example, regulations governing smoking in state office buildings.

Proponents of the local approach toward regulation believe that it is inconceivable that a state law could be passed without a preemption provision and, in that unlikely event, that enforcement by state officials would be relatively ineffectual. (It is interesting that when

\textsuperscript{1}Technically, only the legislative committee of the coalition was formed in mid-1990; the coalition is not expected to be fully formed until late 1991.
queried about the preemption issue, several legislators indicated that they would not support a bill that contained a preemption clause.) To a large extent, support for local regulation stems from the impressive historic success that advocates of local smoking-control regulations have enjoyed in getting such regulations passed by city councils.

A second source of conflict that exists both between groups within the coalition and between the coalition and the recently departed faction centers on legislative strategy. Essentially, all supporters of smoking-control legislation fall into one of two camps: those who believe in what might be referred to as an incrementalist approach toward legislation and those who believe in a more comprehensive approach. The former approach argues for identifying a legislative agenda; obtaining consensus among coalition members on the relative importance, political feasibility, and timing of each agenda item; and then selecting an item or small group of items that would be vigorously pursued during a particular legislative session. In contrast, the latter approach argues simply for gaining a consensus among coalition members on a legislative package—which may involve, for instance, a series of legislative proposals in the areas of excise tax increases, clean indoor air initiatives, and restrictions on teenage access to cigarettes—and lobbying for passage of the entire package, one legislative session after the other.

A third area of conflict involves determining the relative importance of clean indoor air laws and youth access laws. Although most anti-smoking advocates agree that legislative action is ultimately required on both fronts, there is far less agreement on where lobbying and other resources should best be spent in the short run. Approximately half of the anti-smoking forces believe that passage of a clean indoor air law should be given top priority; the remainder believe that youth access comes first.²

²It should be noted that with respect to youth access, the issue of state versus local control remains a controversial one. Specifically, there is little agreement on whether laws restricting minors' access to cigarettes should be a state or local responsibility. Advocates for the state approach maintain that a state law is the only way to ensure both uniformity and comprehensiveness of coverage. Advocates of the local option hold that the state does not have the resources to enforce any law that they may pass, whereas localities are more capable of mounting effective enforcement efforts. In addition, advocates of the local approach believe that it is easier to pass legislation restricting youths' access to cigarettes at the local level because opponents of such legislation are far less organized than at the state level. Apart from the tobacco lobby, the retailers', grocers', and gasoline station owners' associations have shown an active interest in opposing further restrictions on minors' access to cigarettes at the state level.
In addition to the three basic areas of conflict outlined above, there are considerable differences among anti-smoking advocates, both within and outside of the coalition, in personal style and approach. On the one hand, there are the so-called single-issue “advocacy groups,” which tend to be quite confrontational and to view their struggle in more personal terms. That is, they often appear to be willing to explain events in terms of the motivations and actions of particular actors in the legislative process rather than in terms of institutional or organizational behavior. As one observer noted, these groups generally do not present the “sophisticated, quasi-bureaucratic front that, say, the Department of Health and the major voluntary health associations are capable of.” The net contribution of these groups to the anti-smoking cause is uncertain. One interviewee reported that the “credibility of the coalition is jeopardized by the radical anti-smoking forces”; however, a coalition member suggested that the advocacy groups are useful for drawing attention to the issue and that the passion they often display for the issue is “infectious.”

The more moderate anti-smoking groups, on the other hand, are generally far less confrontational and much more willing to craft compromises than their advocacy group counterparts. Among the groups that could be counted in this camp are the major voluntary health organizations (i.e., the heart, cancer, and lung associations), the state medical association, and the state department of health. As one interviewee noted, these groups tend to be “careful advocates,” who are unwilling to assume a “vigilante role.” In contrast to the advocacy groups, representatives of these organizations tend to view the smoking legislation battle in more institutional terms and, in general, appear to be more patient with legislators and more tolerant of their opponents.

The anti-smoking forces have paid a heavy price for their demonstrated inability to agree on such fundamental issues as those discussed above and, to a certain extent, for airing their differences in public. As one member of the coalition put it, “The coalition can’t stay together long enough to accomplish anything.” Perhaps more important is the fact that several legislators expressed concern over the lack of cohesiveness that exists among the anti-smoking forces. One key legislator reported that he received “mixed signals from local [anti-smoking] groups” and that they “need to come to the table with the same purpose, develop a strategy, and stick with it.” In short, unless anti-smoking advocates are able to resolve the issues outlined above and present a united front to both legislators and the public at large, it is unlikely that their efforts to enact additional statewide smoking-control legislation will meet with success.
The Role of Key Legislators

The level of dissension that exists both within the coalition and between the coalition and other anti-smoking groups has, in part, affected the amount of attention and effort that key legislators are willing to devote to the issue. As one observer put it, "the legislators don't make issues, they just respond to what's out there," and unfortunately, as indicated above, "what's out there" isn't very clear from the legislators' vantage point. One legislator, who was openly critical of both the coalition's substance and style, argued that to become effective the coalition needs to present a "Wall Street" image and must learn to make "logical, statistical, verifiable arguments about the hazards of smoking."

This latter point surfaced in one form or another in several interviews with legislators. Virtually all of the legislators expressed the view that the coalition had not been very effective in educating both the legislators and the public on the health consequences of passive smoking and the benefits (both health and otherwise) associated with imposing state-level restrictions on smoking in public places. In fact, a number of interviewees noted that the coalition has to date been unsuccessful in framing the issue in terms of health. Conversely, the tobacco industry has been relatively successful in its attempts to frame the issue in terms of individual rights.

To be sure, the coalition's lack of effectiveness explains only part of the legislative leadership story, as a variety of other factors have contributed to the relative dearth of leadership on the issue. As indicated above, in Arizona there is a general antipathy toward legislating behavior, even in the presence of clear external costs. One legislator put it bluntly: "Legislators don't like to tell people what they can and can't do." It is therefore not surprising to find that legislators see themselves in essentially reactive positions, relying on the coalition's efforts to present the case for smoking-control legislation and unwilling to get out front on the issue.

A second factor that has dampened legislators' enthusiasm for additional statewide legislation was AZSCAM, a recent political scandal that resulted in the forced resignations of several legislators and generally proved an embarrassment to the legislature and the state. Several sources reported that in the wake of AZSCAM, the Speaker of the House, Jane Dee Hull, requested that committee chairs refrain from hearing any controversial bills.

Finally, one cannot discount the influence of tobacco industry lobbyists on legislators. One legislator commented that the industry uses the services of "well-respected" lobbyists. Though not mentioned by
name, it seems clear that the legislator was referring to Robert Usdane, who formerly served as president of the state Senate and currently serves as a lobbyist for a major tobacco company. To date, the tobacco industry's lobbying strategy has apparently succeeded in blocking the progress of all tobacco-control bills through the legislative process.

The Role of the Medical/Public Health Community

In contrast to the role played by its counterparts in several of the other states studied, the role played by the Arizona Medical Association in the smoking-control legislative process has been, historically, quite limited. For instance, the association has not been a vocal member of the coalition and has heretofore devoted only a small fraction of its substantial lobbying resources to the cause. In speaking of the association's role, one coalition member said simply that they were "opinion readers, not opinion leaders." Somewhat surprisingly, several coalition members were unable to name the current association representative to the coalition—one went so far as to ask who the association representative was, took the name down, and said, "I really should give him a call."

There are some signs that the association has started to increase the level of effort devoted to smoking-control activities. Apart from their expressed interest in becoming more involved in this area, the association during the past year developed a comprehensive tobacco policy—which was modeled largely on the previously mentioned report published in June 1990 by the Department of Health Services. Moreover, association members and officials suggested that there was a general sentiment for being more supportive of public health initiatives. This sentiment appears to be derived from a genuine desire to protect and improve the public's health as well as enlightened self-interest. With respect to the latter, several observers noted that the association's support for public health issues would strengthen the association's ability to garner legislative support for "pocketbook" issues (e.g., tort reform) as well as other issues related to how medical care is organized and financed in the state.

Until recently, the involvement of the Arizona Department of Health Services in tobacco-use prevention and control initiatives was limited. The department's visibility in the area of tobacco control increased in 1988 when its director appointed a steering committee to develop a mechanism for coordinating state tobacco-use prevention and control efforts. As mentioned above, this steering committee and its subsequent report motivated the formation of the coalition.
Finally, the Arizona Public Health Association was notable for its absence in smoking-control-related activities. Our interviews indicated that the association, though nominally a member of the coalition, has not played a significant role either as a member of the coalition or on its own accord.

The Effect of Local Regulations on the Prospects for Statewide Legislation

Unlike respondents in Texas who were quite outspoken about the effects of strong local anti-smoking regulations on the prospects for strong statewide legislation, virtually none of the respondents in Arizona addressed this issue directly. Rather, discussions of local versus state regulations tended to be more philosophical and revolved around the issue of whether such regulations should be implemented at the local or state level.

Still, one cannot help but think that, as in Texas, the relatively widespread presence of local anti-smoking ordinances weakens the enthusiasm of state legislators to introduce smoking-control bills, although none of the legislators interviewed explicitly acknowledged this to be the case. However, in the event that statewide legislation is considered in the future—then again as we observed in Texas—the widespread adoption of local anti-smoking regulations may reduce the chances of success for tobacco industry attempts to include a preemption clause in a statewide bill. That is, given Arizonans’ preference for local control, state legislators may be unwilling to preempt local ordinances in a statewide bill.

EPILOGUE AND CONCLUSION

The problems facing advocates of additional statewide smoking-control legislation in Arizona are perhaps best illustrated in what may be viewed as a fitting epilogue to the Arizona case study. The incident centers around a bill that had passed the state’s Senate during the week that we conducted our interviews in the state.

The Senate bill, which was passed by a considerable margin, prohibited smoking in state office buildings except in designated areas. Moreover, the bill required that these areas have ventilation systems that functioned independently of the building’s main ventilation system. Ironically, in passing the bill, the Senate exempted itself—a provision noticed by the press and others who publicly chastised the legislators for their apparently hypocritical behavior.
Subsequently, the House passed a similar bill, also by a wide margin. The House bill, however, did not exempt the two legislative bodies. As a result, a conference committee was appointed to reconcile the two bills.

The speaker of the House appointed two known chain-smokers to sit on the conference committee. According to one source, the appointments were strongly supported by one of the industry’s key lobbyists who, allegedly, has enjoyed a longtime friendship with the speaker and her family.

The result of the conference committee’s efforts—described as “bizarre” by one coalition member—serves as a commentary on both the coalition’s efforts and the effectiveness of their allies in the legislature. Rather than simply address the (relatively minor) discrepancy that existed between the two bills, the conference committee added an anti-discrimination provision to the bill and seriously weakened the bill’s provision that banned smoking in public buildings by replacing it with a considerably weaker provision. With respect to the latter provision, one interviewee exclaimed that “We would have been better off getting nothing.” Much to the chagrin of the coalition’s members, the bill reported out of the conference committee passed both houses and was recently signed into law.

Though certainly disappointing to smoking-control advocates, the outcome of the conference committee’s deliberations is not surprising. In fact, given the nascent and unsettled state of the coalition and the absence of strong legislative leadership, the prospects for passing statewide smoking-control legislation of any consequence in the near, and perhaps not so near, future are bleak.
Appendix F
TEXAS CASE STUDY

INTRODUCTION

For several reasons, Texas presents an interesting case study of smoking-control legislation. First, existing state law governing smoking in public places is relatively weak. Essentially, existing law requires that smoking be prohibited in a half dozen or so public places—including public transportation systems, elevators, health facilities, libraries, museums, theaters, and schools—except in designated areas (Tobacco-Free America, 1990). In an effort to strengthen the existing law, additional anti-smoking legislation has been introduced in the current and four previous legislative sessions. Thus far, however, no such legislation has been signed into law. Consequently, Texas presents an opportunity to examine an ongoing struggle to enact statewide legislation.

Second, in contrast to the weak state-level legislation, many localities have passed ordinances that substantially restrict smoking in public places. According to a recent survey conducted by the Texas Department of Health’s Office on Smoking and Health, 88 of Texas’s 200 largest cities, which cover over 40 percent of the state’s population, have passed one or more anti-smoking ordinances (Texas Department of Health, 1991).

Finally, although many Texas legislators have been reluctant to support statewide anti-smoking legislation, in a special session held during the summer of 1990, the legislature passed a law raising the state’s excise tax from 26 to 41 cents per pack, leaving Texas with the highest cigarette excise tax in the nation. It is particularly curious that, according to many observers of the legislature, the tax law was enacted in the face of little opposition. To a great extent, this lack of opposition is attributable to the fact that potential alternative sources of revenue—in particular, a state income tax—were even less attractive to legislators. Moreover, one informed source indicated that tobacco industry opposition to the tax bill was minimal because they received assurances that additional excise taxes would not be imposed in the foreseeable future. Whether such assurances were also given with respect to other forms of tobacco-control legislation (e.g., clean indoor air legislation) is of course uncertain.
OVERVIEW OF THE POLITICS OF ANTI-SMOKING LEGISLATION

Proponents of anti-smoking legislation in Texas appear, on the one hand, frustrated over the failure of past efforts to enact stronger statewide anti-smoking laws and, on the other hand, optimistic about the future. To a large extent, the immediate source of much of the frustration is the repeated failure to pass a comprehensive anti-smoking bill in the House. This is in sharp contrast to the Senate, where comprehensive clean indoor air bills passed easily in the last several legislative sessions. The unwillingness or inability of the House to pass such a bill stems, in turn, from several sources, including intense and strategic tobacco industry lobbying efforts directed at key legislators, relatively lackluster legislative leadership, and, perhaps, a general antipathy on the part of many legislators to regulate personal behavior in any way, shape, or form. With regard to the latter point, several observers interviewed noted that Texans are generally suspicious, if not disdainful, of government activities in general. As one observer in particular put it, "the higher the level of government, the greater the degree of suspicion."

Despite these formidable setbacks and obstacles, many smoking-control advocates expressed hope that legislation favorable to their cause would be forthcoming—although few believed that a comprehensive smoking-control bill would emerge from the current legislative session. A number of factors, discussed in detail below, appear to have contributed to this newfound sense of optimism. First, the state's medical society has embraced the anti-smoking cause and has committed substantial lobbying resources to affect the course of anti-smoking legislation. Second, the Texas Interagency Council on Smoking or Health—a broad-based coalition comprising the major voluntary health organizations, the state department of health, the state medical association, and other such organizations (hereinafter referred to as the coalition)—has made a determined commitment to pursue a sophisticated legislative strategy, including the use of experienced lobbyists. And finally, recent studies published by the Environmental Protection Agency (in draft form) and other agencies, as well as independent researchers, have strengthened the scientific evidence attesting to the adverse health effects of environmental tobacco smoke. As a result, the members of the coalition are confident that they will better be able to make their case for smoking-control regulations on health grounds.

Opponents of additional smoking-control legislation are primarily limited to the tobacco companies and their representatives, the most
prominent of which is the Tobacco Institute. Although the Tobacco Institute maintains a strong lobbying presence in Texas, it refused to allow its representatives to be interviewed for this study. Consequently, we necessarily had to rely on other sources for information regarding the industry's legislative strategies and activities.

To date, the industry has been quite successful in blocking the passage of statewide legislation, which stands in marked contrast to their record at the local level. According to several observers, including legislative staff members, the industry has generally concentrated its lobbying resources in the House, essentially ignoring the Senate where, as noted above, strong legislation restricting smoking in public places passed handily in the last two legislative sessions. Moreover, in comparison to the anti-smoking forces, the tobacco industry has been successful in using sophisticated direct-mail techniques to mobilize grass-roots support among smokers. (It is somewhat paradoxical to note that although this strategy has succeeded at the state level, the industry has apparently not been able to mobilize grass-roots support at the local level.)

The Coalition's Strategy

The Texas Interagency Council on Smoking or Health (the coalition) is in the process of evolving from a relatively loosely formed group into a tightly knit entity determined to see stringent anti-smoking legislation enacted. During the first 15 years of its 20-year history, the coalition met infrequently to exchange smoking-related information, discuss smoking-related public policies, and develop anti-smoking educational programs. For approximately the next five years, the coalition has shifted its focus to pursue a legislative strategy.

The coalition's legislative strategy contains four basic components. First, as already discussed, the coalition plans a concerted lobbying effort, primarily through the Texas Medical Association's (TMA) professional lobbyist. Several interviewees have pinned their hopes for new legislation on the ability of the TMA's lobbyist to compete effectively with his tobacco industry counterparts. Second, the coalition has started to enlist the voluntary health associations' networks of volunteers to organize grass-roots support for statewide legislation. Third, the coalition is planning to make extensive use of the media by conducting meetings with editorial boards as legislative battles heat up. Finally, the coalition has increased its reliance on technical support materials, provided to a large extent by the Department of Health, to educate both legislators and the general public on the
health hazards associated with smoking and environmental tobacco smoke.

It is interesting to note that the Department of Health’s provision of technical support to the coalition represents virtually the sum total of all executive branch activity in this area. For instance, the governor’s office—which has traditionally acted from a position of weakness in Texas politics—has not been involved in the smoking-control debate. However, several of the interviewees suggested that the new governor, Ann Richards, may assume a more aggressive role in enacting stringent legislation once progress is made in resolving the state’s serious budgetary problems.

Finally, it appears that, heretofore, the coalition has not succeeded in shaping the terms of the smoking-control debate to its advantage. That is, for the most part, the issue remains one that is framed in terms of individual rights, not health. Consequently, given Texans’ general predisposition to object to any and all attempts to regulate individual behavior, the coalition faces an uphill battle on this particular front. However, if the coalition can make a cogent argument for smoking-control legislation on health grounds—by essentially pointing to the fact that smokers impose external costs on nonsmokers—then their efforts to enact additional smoking-control legislation will have a greater probability of success.

The Role of Key Legislators

Virtually all of the individuals interviewed pointed to several powerful legislators as a contributing factor to the failure of the House to pass significant anti-smoking legislation. In particular, the Speaker of the House and the Chairman of the House State Affairs Committee were singled out as the two individuals most responsible for impeding the progress of anti-smoking bills in the legislature.1 The degree of importance placed on the role of these legislators, however, varied considerably across interviewees. One respondent went so far as to say that an anti-smoking bill of any consequence would not pass “until the Speaker died,” and a somewhat more sanguine observer noted that eventually—as the evidence attesting to the adverse health consequences of passive smoking mounts and is disseminated—even the Speaker will have to answer to his constituents. In

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1Ironically, the Texas Cancer Council, a government agency responsible for funding and initiating cancer-prevention efforts, presents an annual service award that bears the name of the Speaker of the House, Gib Lewis. The Gib Lewis Award was created in recognition of Mr. Lewis’s efforts in founding the council.
the meantime, however, this threat appears less than formidable, as virtually all legislators interviewed reported hearing little from their constituents on the issue.

In the current and last several legislative sessions, the Speaker referred key smoking bills to the House State Affairs Committee, rather than to the Health and Human Services Committee. As several observers pointed out, the Speaker found an ally in the State Affairs Committee Chairman who is willing to prevent the legislation from reaching the floor of the House, where it would allegedly meet with strong support. In fact, a number of clean indoor air legislation proponents indicated that the Chairman of the State Affairs Committee was even unwilling to give the bill a “fair hearing” in the committee.

The following real or perceived reasons were proffered by anti-smoking advocates for the reluctance of the Speaker and the Committee Chairman’s opposition to the bill, including large tobacco industry campaign contributions, the Speaker’s ownership of a large alcoholic beverage distributorship (and, as one observer put it, “Alcohol and cigarettes go hand in hand”), and what appears to be low constituent interest in seeing the bill become law.

Although several key legislators have been identified as major impediments to anti-smoking legislation, the anti-smoking cause has also suffered from an absence of legislative enthusiasm. Although anti-smoking advocates generally have no difficulty finding bill sponsors, they have yet to find a legislator willing to embrace such a bill and make it his or her top legislative priority. As one observer remarked, “None of the legislators see [smoking in public places] as a vital issue.” In part, the observed lack of legislator enthusiasm may result because the coalition’s strategy of mobilizing grass-roots support has yet to take hold. None of the legislators interviewed reported strong constituent support for anti-smoking legislation.

The current legislative session illustrates how legislator interest in tobacco-control legislation is often supplanted by other issues. The House bill’s sponsor introduced clean indoor air legislation early in the session, much to the surprise of coalition members, who at the time were still in the process of developing their legislative strategy. However, it has become clear that although anti-smoking legislation is near and dear to the heart of the bill’s sponsor, other issues (namely, the proposed state lottery) will take priority. According to one legislative staff member’s estimate, the smoking bill falls fourth or fifth on the sponsor’s priority list.
The Role of the Texas Medical Association

From the mid-1980s to the present, the role of the Texas Medical Association (TMA) has evolved from a position of relative obscurity to a position of leadership in the effort to enact a statewide tobacco-control law. To a certain extent, this transformation has resulted from the efforts of one of TMA's members, a longstanding and tenacious anti-smoking activist. With a handful of colleagues and TMA staff members, this individual successfully convinced the TMA leadership, and subsequently many of its members, of the importance of the smoking issue, both in terms of protecting the public's health and in advancing other TMA interests (e.g., so-called "pocketbook" issues).

The TMA's record in passing anti-smoking resolutions and enacting anti-smoking policies is impressive. Since 1988, the TMA has passed 17 such resolutions and policies, ranging from statements of support for anti-smoking legislation to proscriptions against investing in tobacco stocks. Moreover, the TMA's strong show of support for anti-smoking legislation lends credibility to the activities of both the voluntary health associations and the single-issue, anti-smoking groups, which, in some quarters, are viewed as "fringe" organizations whose claims should be met with skepticism.

Perhaps the TMA's largest contribution to the anti-smoking cause is the commitment of their professional lobbyist's services. Several interviewees noted that past attempts to enact anti-smoking legislation failed, at least in part, because of an inability to compete with the industry's lobbying resources. The staff of the voluntary health associations, who were amateur lobbyists at best, were no match for the sophisticated and highly experienced industry "hired guns."

The Effect of Local Regulations on the Prospects for Statewide Legislation

Respondents differed considerably with respect to their views of how the presence of strong regulations in a large number of localities is likely to influence the prospect and shape of state legislation. For instance, one observer noted that the proliferation of local anti-smoking regulations meant that a statewide law was not "the end all and be all." This mentality may, in part, explain the apparent lack of passion that legislators have displayed for a statewide law. On the other hand, several respondents reported that in their view it was important to pass a statewide law precisely because a large number of localities had passed laws, and that in the interests of equality a state law
should be passed to ensure that residents of the remaining areas are accorded at least some degree of protection.

One interesting potential consequence of the widespread adoption of local anti-smoking regulations is that they may serve to stymie tobacco industry attempts to include a preemption clause in a statewide bill. This relates to a point made earlier concerning Texans’ preference for local control. That is, state legislators may be reluctant to include any provision in a statewide clean indoor air law that could potentially be used to undo local measures.

CONCLUSION

Statewide anti-smoking legislation in Texas faces an uncertain future. On the one hand, the broad coalition of anti-smoking forces appears tenacious and capable of implementing a well-orchestrated legislative strategy. On the other hand, the tobacco industry, through its exacting lobbying efforts, maintains a virtual stranglehold on tobacco-control legislation in the House. All things considered, the prospects for passage of a comprehensive clean indoor air bill during the current legislative session seem dim. However, the coalition stands a reasonable chance of witnessing the passage of a bill that would impose restrictions on smoking in some public places or restrict the distribution or sale of cigarettes and other tobacco products in the not too distant future.
Appendix G

HISTORICAL BACKGROUND OF TOBACCO LEGISLATION

During most of the 19th century, there was little anti-tobacco activity in the United States. By the turn of the century, however, 14 states had enacted anti-smoking laws. Two themes characterized this early legislation. One focused on the fire hazard created by smoking, and the other concentrated on the morality of smoking. Eventually, however, opposition to smoking on moral grounds was swept aside by the economic benefits associated with tobacco production and consumption. As the popularity of smoking grew, states realized that cigarette taxes were an important source of revenue, so early anti-smoking legislation was repealed. In fact, by 1927, all state statutes were repealed and the anti-tobacco movement was legally, as well as practically, dead. The political tide did not begin to turn again until the 1960s. In what follows, we describe briefly the history of anti-smoking legislation in the United States.

OPPOSITION TO SMOKING ON MORAL GROUNDS

Despite a few 17th century restrictions, most of the earliest anti-smoking legislation was not enacted until the second half of the 19th century, primarily in response to the fire hazard created by smoking. In 1847, a Boston ordinance prohibited smoking on public streets because of the extreme fire danger to wooden structures. The court upheld the ordinance as a valid exercise of the state’s police power.¹

In 1856–57, the British medical journal *Lancet* featured an issue in which 50 doctors expressed their views on “The Great Tobacco Question.” Various doctors associated tobacco with increases in crime, nervous paralysis, loss of intellectual capacity, and vision impairment. But the *Lancet* editors argued that since tobacco was so widespread, it must have some good or at least pleasurable effects. The journal’s editors concluded that if the evil effects of tobacco were as dreadful as these doctors claimed, the human race would have ceased to exist (Wagner, 1971).

By the late 1800s, many observers thought cigarettes were corrupt and morally repugnant. For example, in 1884, the New York Times warned that smoking could “ruin the republic.” Women who smoked were considered promiscuous, and were warned they could become sterile, mustachioed, or tuberculous. In the 1890s, Lucy Page Gaston led a Chicago-based anti-tobacco campaign modeled on the anti-alcohol campaign. Similarly, Henry Ford spoke against smoking, and Thomas Edison refused to hire smokers (Wagner, 1971).

At the turn of century, 14 states passed laws banning the production, sale, advertisement, or use of cigarettes within their boundaries. For example, in 1897, Tennessee adopted a statute to prohibit the sale of cigarettes. The statute was upheld by the Tennessee and United States Supreme Courts as a valid exercise of a state’s police power to protect public health. In 1901, New Hampshire made it illegal for any person, firm, or corporation to produce, sell, or store for sale any form of cigarette. A 1907 Illinois law made the manufacture, sale, or gift of a cigarette punishable by a fine of not more than $100 or jail for not more than 30 days. In New York, women were forbidden to smoke in public.

As smoking grew in popularity, however, the laws were not enforced, and in many instances were ultimately repealed. By 1909, when the last of these early state laws was passed, national cigarette sales were twice what they had been five years earlier. Cigarette smoking increased dramatically from 1930 on, with the greatest percentage gains during and immediately following World War II. In 1945, 267 billion cigarettes were sold, 12 percent more than in 1944, 48 percent more than in 1940, and 124 percent more than in 1930 (Wagner, 1971).

**OPPOSITION TO SMOKING ON HEALTH GROUNDS**

Accompanying this growth in smoking popularity, scientific evidence regarding its ill effects began to be published. In the 1930s, the medical community began to investigate the increase in lung cancer. By the 1940s, scientific reports began to associate smoking with cancer, heart disease, and other adverse health effects. Evidence mounted in the 1950s.

In 1964, the first Surgeon General’s Report on Smoking and Health was published. The report concluded that smoking was causally related to lung cancer, that it was the most important cause of chronic

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2 *Austin v. Tennessee*, 179 U.S. 343 (1900).
bronchitis, that it increased the risk of dying from chronic bronchitis and emphysema, and that it caused coronary disease. In response to this report, in 1965, Congress passed the Cigarette Labeling and Advertising Act, which required health warnings on all cigarette packages. Then, in 1967, the Federal Communications Commission ruled that the "fairness doctrine" applied to cigarette commercials. As a result, all broadcasters who carried cigarette advertising had to provide equal time warning the public about cigarettes. In 1968, 1300 antismoking messages were aired by the three major networks (Lewit, Coate, and Grossman, 1981). A year later, Congress passed the Public Health Cigarette Smoking Act of 1969 banning all cigarette advertisement from radio and television, thus eliminating the need for broadcasters to provide equal time for anti-smoking messages.

The most recent scientific debate on smoking concerns the effects of passive smoking. In 1990, the Environmental Protection Agency released a draft report that reviewed 24 epidemiological studies. The EPA concluded that passive smoking causes 3800 lung cancer deaths each year (Altman, 1990), corroborating an earlier report on passive smoking from the Surgeon General (U.S. Department of Health and Human Services, 1986).

Passive smoking appears to be a particular risk to infants and children. In a recent study on lung cancer and exposure to tobacco smoke in the household, Janerich and Thompson (1990) concluded that 17 percent of lung cancers among nonsmokers can be attributed to high levels of exposure during childhood and adolescence. Passive smoking has also been found to be a risk factor for other cancers. For example, a case-control study of women in Utah found that exposure to passive smoking three or more hours a day almost triples the relative risk of cervical cancer in nonsmokers (Slattery et al., 1989).

**RECENT STATE AND FEDERAL ANTI-SMOKING LEGISLATION**

As the scientific evidence of tobacco's harmful effects mounted, legislative activity grew on both the state and federal levels. As of 1970, only 14 states had laws that limited smoking. In 1977, 392 bills were introduced in the various state legislatures, and 28 states enacted 44 bills into law (Christoffel and Stein, 1979). Although most of these bills involved matters such as taxation of cigarettes, or control of transport, a considerable number sought to limit cigarette smoking in one way or another.
Today, 45 states and the District of Columbia restrict smoking in some manner in public places. These laws range from nominal restrictions to very extensive ones, but only a few states have enacted comprehensive clean indoor air laws that restrict smoking in a wide variety of public places (Tobacco-Free America, 1990). For example, Alaska, Connecticut, Maine, Minnesota, Nebraska, Montana, New Hampshire, New York, Rhode Island, Utah, and Wisconsin all have clean air laws that restrict smoking in public places, including private and public worksites. In contrast, Kentucky restricts smoking only in schools, and Mississippi does not allow smoking on school buses (Tobacco-Free America, 1990).

However, the tobacco industry continued to be a strong opponent, particularly on the federal level. In fact, until 1983, when Congress doubled the excise tax on cigarettes to 16 cents a pack, the tobacco industry had never lost a legislative battle. Of the 145 Congressional bills identified as “anti-smoking” by the Tobacco Institute in 1989, only one—to ban smoking in airline flights of less than two hours (later extended to flights under six hours)—passed (Sylvester, 1989).
Appendix H
SMOKING LEGISLATION STUDY INTERVIEW GUIDE

I. Background

A. History of state’s smoking-related legislation
   1. Excise taxes
   2. Restrictions on smoking in public places
   3. Other smoking legislation (e.g., sales to minors and vending machines)

B. Current/most recent legislation
   1. Perceptions of factors that motivated most recent legislative action
   2. Components of legislation (nature of restrictions, enforcement provisions, etc.)

C. Similarities and differences between smoking-related legislation and other recent public health legislation (e.g., alcohol use and auto safety)

II. Factors affecting smoking legislation

A. Roles played by key actors (local, state, and federal) and their relative importance
   1. Legislators
   2. Executive branch agencies
   3. Tobacco industry lobbyists
   4. Health associations
   5. Medical society
   6. Anti-smoking groups
   7. Media
   8. Other organizations, institutions, or individuals

B. Public opinion
   1. Influential surveys
   2. “Sentinel” events

C. Public health environment

D. Relative importance of individuals vs. organizations/institutions
III. Strategies for shaping smoking legislation  
   A. Strategies employed by each of the key actors  
      1. How were various strategies developed?  
      2. Which judged to be successful/ unsuccessful?  
   B. Strategies contemplated to influence future legislation  

IV. Lessons learned  
   A. Future state legislation  
   B. Other states  

V. Additional contacts and documents
Appendix I

LETTER TO INTERVIEWEES

7 March 1991

Assemblyman
New York State Assembly
Room 522
Legislative Office Building
Albany, New York 12248

Dear Assemblyman:

Thank you for agreeing to meet with me on 2 April 1991 in Albany (assuming your schedule permits) at 11:00 to discuss New York state tobacco control legislation. I will contact to confirm the meeting.

For your information, I am enclosing a project summary describing the study’s goals and methodology. For our meeting, I will be interested generally in your observations about the critical factors shaping the Clean Indoor Air Act, and the factors likely to shape the current legislation. In particular, I am interested in your observations about the role of various lobbying groups, and how important political leadership was to the legislative outcome.

The following are among the questions I would like to discuss with you. What were the primary legislative obstacles to passing the Clean Indoor Air Act? What lessons were learned in the Clean Indoor Air Act debate that are applicable to the proposed adolescent smoking legislation? What role did the Governor’s office play in the legislative debate? How important were the coalitions formed by various lobbying groups to the legislative outcome? How important was party affiliation and party control of the legislature to this process? What strategies and arguments raised by anti-smoking organizations were particularly effective in securing passage of the legislation? What arguments were not persuasive? What strategies and arguments raised by the tobacco industry were effective? What tobacco industry arguments were ineffective? How important were tobacco control initiatives to your constituents?

I look forward to meeting you. If you have any questions, please contact me. Also, if you have any materials that you think I should review prior to our meeting, please send them to me.

Sincerely,

Peter D. Jacobson, JD, MPH
Senior Behavioral Scientist

PDJ:mp
Enclosure
BIBLIOGRAPHY


