ORAL HEALTH AMERICA
National Spit Tobacco Education Program (NSTEP)
Spit Tobacco Report Card 2006
National Grade: D

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BACKGROUND

Several factors prompt Oral Health America and its National Spit Tobacco Education Program (NSTEP) to release this report card on spit tobacco use by high school males and on state spit tobacco excise taxes. New test "smokeless" tobacco products were introduced into the market during the summer months. In addition, debate continues on FDA control over tobacco products, including unregulated spit and "smokeless" tobacco products, and Congress has not acted thus far to change FDA rules and regulations despite significant lobbying efforts by multiple and competing interests. Finally, Oral Health America is concerned by ongoing anecdotal reports of significant use of spit tobacco products by U.S. forces overseas and visible marketing tactics by the tobacco industry aimed at our troops.

NEW PRODUCTS

Industry analysts, market researchers, health care providers, tobacco control advocates and many others are watching as two new "pouch" tobacco products are marketed to the public. These products do not need to be chewed or spat, as users swallow the tobacco juices produced as the pouch rests along the gum line.

The products—one by Reynolds American, Inc., now the parent company of Conwood, and the other, the first foray into the "smokeless" market by tobacco industry giant Phillip Morris—are currently being tested in U.S. cities. With continued declines in smoking rates, increases in cigarette excise taxes and clean indoor air acts, the chances for tobacco companies to expand and market "smokeless" and "spitless" product lines have never been greater. No doubt industry players Swedish Match and US Smokeless Tobacco Company will be introducing new products to compete in these areas as well.

The bottom line is that teenagers probably will be attracted to them, and it is important for the public to understand that there are health risks, including potential nicotine addiction and cancer, involved with spit or spitless "smokeless" tobacco use. Coming from companies that have clearly focused products on younger users, it is hard to conclude that these "pouches," unregulated by FDA standards, are solely designed for the adult smoker looking for a less visible alternative that does not cause lung cancer.

FDA DEBATE

In theory, FDA control over tobacco products appears to be a good idea. Regulation could limit the amount of nitrosamines, or cancer-causing agents, in tobacco products, in addition to a host of other generally known ingredients. Regulation could significantly limit tobacco company marketing that encourages younger users, and discourages users from quitting entirely. Efforts to impose FDA regulation have so far failed in Congress for a host of reasons, including division from within the public health and tobacco control communities, and uncertainty about tobacco industry response to FDA control over products, marketing, and sales practices.

Tobacco company Phillip Morris is in favor of FDA regulation, and some (including Oral Health America) wonder why a tobacco company would come out in support of

legislation limiting its reach to the public. It could be that as the industry leader, Phillip Morris is in the best position to respond successfully to regulation, which might only increase its dominance in the market place. All concerned will continue to debate the issue as FDA authority is reconsidered by legislators after the 2006 elections.

SPIT TOBACCO MARKETING TO U.S. TROOPS

Oral Health America has been contacted by a number of health professionals in the armed services concerned with the level of spit tobacco use by troops in Iraq. They see clear signs of nicotine addiction, thwarted attempts to quit, periodontal disease, and tooth decay as a direct result of spit tobacco use. In one e-mail to Oral Health America, a health professional said,

> *I have noticed that the use of all forms of tobacco shoots through the roof on deployments. There is a lot of stress from everywhere, on top of what ever dependency they already may or may not have. There is a huge switch from cigarettes into chewing tobacco due to the fact that there are so few smoking areas and in some places lighting a cigarette can get you shot by a sniper by giving away your position. Plus it turns into a social thing: walk into the gym at any moment and I promise, you will see at least five people lifting weights in between spitting into Gatorade bottles. I cannot even count how many times I have heard: "I am going to quit after I finish this can."*

There is no focus on what happens when a user decides to quit using spit tobacco when deployment ends.

Tobacco companies have recognized the tremendous opportunity in supplying troops with free product. While unrequested donations are illegal, companies are making it very easy for soldiers to request and receive product over the internet. A number of web sites feature pictures of men and women benefiting from tobacco company largesse. In war, the health consequences of tobacco use may seem insignificant. On the other hand, it seems like the perfect opportunity for the tobacco industry to reach out to new users, inevitably resulting in increased numbers of young people who are addicted to nicotine.

SPIT TOBACCO IS NOT HARMLESS

Despite suggestions by the tobacco control industry, and by some health proponents, spit or “smokeless” tobacco products are a health risk. They can cause gum disease and lesions in the mouth. High levels of sugar can contribute to tooth decay, a significant problem for those without access to routine dental care. “Dipping” or “chewing” can be just as bad for pregnant women as smoking. Users are at increased risk of cardiovascular disease, including heart attack.

Throat and mouth cancer are possible, and risks vary depending on the amount of cancer-causing ingredients in any given product. Oral cancer is one of the most insidious, deforming cancers in human experience, and five-year survival rates are low. These tobacco products may also be linked to other cancers, including gastrointestinal

and pancreatic cancer, and more research is needed to clarify those links. Moreover, without FDA oversight of spit tobacco products, there is no real way of knowing what tobacco companies put in these products.[1]

In addition, nicotine content can be the same or higher than in a cigarette, depending on the spit or "smokeless" product, and how much the user has in his or her mouth. The average can of "dip" or "snuff" has as much nicotine as four packs of cigarettes. Nicotine is a highly addictive drug, and spit tobacco products can be just as easy to get hooked on and just as hard to quit as cigarettes.

Children and adults may not have the same understanding of the health consequences of spit tobacco use that they have of smoking. Children who see spit tobacco use by role models, including sports figures and family members, may have very little understanding of the potential harm to the mouth, throat, and stomach, and of nicotine addiction.

With an increase in public bans on smoking, tobacco companies are bringing new spit and "smokeless" products to the market that are increasingly novel and less conspicuous—raising concern that more children will be lured into use and addiction.[2] The most recent are chewless and spitless (in addition to smokeless). Internal tobacco company documents show a concerted strategy to attract and hook new users with an appealing variety of flavors—that now include apple, peach, vanilla, and berry blend.[3] Marketing efforts by all U.S. tobacco companies are consistent in their use of hip, kid-friendly channels and events to avail products to new and potential users.

SPIT TOBACCO USE DOES NOT LEAD TO TOBACCO CESSATION

There is no valid data to support that the use of spit tobacco is effective as part of a smoking cessation strategy. According to the only significant study of this concept, the proportion of smokers who quit smoking by using spit tobacco (7.0%) was virtually the same as the proportion of smokers for whom spit tobacco did not work as a cessation strategy (6.4%).[4] More recent data from the National Health Interview Survey (NHIS) suggest that only 1% of male former smokers and virtually no female former smokers used spit tobacco to help them quit. One recent study found that the prevalence of smoking was substantially higher among men who had quit using snuff than among

[1] Campaign for Tobacco-Free Kids. Factsheet: Smokeless (Spit) Tobacco & Kids. May 25, 2006. (http://www.tobaccofreekids.org/research/factsheets/index.php?CategoryID=33); Health and Human Services. The health consequences of involuntary smoking: A Report of the Surgeon General, 1986; Smokeless tobacco use and increased cardiovascular mortality among Swedish construction workers. American Journal of Public Health, 1994. Vol 84, No. 3; Hatsukami D, Severson H. Oral Spit Tobacco: Addiction, Prevention and Treatment. Nicotine and Tobacco Research, 1999. 1:21-44; The S.T.O.P. Guide (The Smokeless Tobacco Outreach and Prevention Guide): A Comprehensive Directory of Smokeless Tobacco Prevention and Cessation Resources. Applied Behavioral Science Press, 1997.

[2] Campaign for Tobacco-Free Kids. Factsheet: Smokeless (Spit) Tobacco & Kids. May 25, 2006.

[3] Campaign for Tobacco-Free Kids. Factsheet: Smokeless (Spit) Tobacco & Kids. May 25, 2006.

[4] Novotny, Pierce, Fiore & Davis, Smokeless Tobacco Use in the United States: The Adult Use of Tobacco Surveys, NCI Monograph 8, 25-29, NIH, U.S. DHHS, 1989

those who had never used it, implying that it may be a gateway form of nicotine dosing that may lead to subsequent cigarette smoking—rather than the reverse.[5]

Limited testing may also show that tobacco users are not employing spit tobacco for cessation purposes, but in place of cigarettes in light of new clean indoor air policies.[6] Researchers will be watching to see if cessation strategies simply result in an increase in the number of tobacco users who smoke and use spit tobacco. Proven, safer tobacco cessation therapies are available for those who wish to quit, without the health risks of spit tobacco use.

GRADES AND TRENDS

A. Spit Tobacco Use

The national grade for spit tobacco use by high school males is a "D," reflecting ranges of use throughout the states according to the Centers for Disease Control and Prevention's 2005 Youth Risk Behavior Surveillance System (YRBSS).[7] Grades are given for the percentage of high school males reporting use on one or more of the 30 days preceding the survey.[8]

Alabama, Arkansas, Kentucky, Montana, Tennessee, West Virginia, and Wyoming all receive "F" grades for 21 percent or more of high school males reporting spit tobacco use in the past 30 days. Eleven states earned "D" grades, and thirteen states earned "C"s. Maryland had the lowest reported use, at 4.4 percent, for a "B".

On the whole, prevalence of current spit tobacco use is higher among white males, and especially 12th grade white male students (15.5 percent). Of note, 2005 YRBSS data show the prevalence use was higher among 9th grade female (3.4 percent) than 10th grade female (1.9 percent) and 12th grade female (1.3 percent) students.[9] In general, the use of spit tobacco by teens decreased gradually since peak levels in the mid 1990s, and overall declines have been substantial.[10] However, these important declines may have halted in all grades and are showing indications of reversal.[11]

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[5] Tomar SL. Snuff Use and Smoking in US Men: Implications for Harm Reduction. American Journal of Preventive Medicine, 2002; 23 (3).

[6] E-mail correspondence, Richard Meckstroth, DDS, West Virginia University School of Dentistry.

[7] http://www.cdc.gov/HealthyYouth/yrbs/index.htm

[8] It should be noted that states use very different sampling (for example, some states do not include private and religious schools) and analysis strategies, and many states do not participate in annual YRBS tobacco questions. For those reasons, state-to-state comparisons of YRBS data are not valid. YRBS data show a picture of what is taking place within a given state based on the sampling and strategies utilized.

[9] Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report, Youth Risk Behavior Surveillance—United States, 2005. Vol. 55, No. 55-5. June 9, 2006.

[10] Nelson D, Mowery P, Tomar S, Marcus S, Giovino G, Zhao L. Trends in Smokeless Tobacco Use Among Adults and Adolescents in the United States. *American Journal of Public Health*, May 2006, Vol 96, No. 5. pp. 897-905.

[11] National Institute on Drug Use, National Institutes of Health, US Department of Health and Human Services. *Monitoring the Future: National Results on Adolescent Drug Use—Overview of Key Findings 2005*. pp 38-39. April 2006.

It appears that one important reason for the appreciable declines in spit tobacco use during the late 90s was the fact that an increasing proportion of young people were persuaded of the dangers of using it. As with use though, perceived health risks of spit tobacco leveled or declined in high school grades in 2005. So while 44 percent of high school seniors see "great risk" in using spit tobacco regularly, that percentage has not changed significantly in the past three to four years.[12] Despite the best efforts of state dental directors, oral health coalitions, and many others working to maintain state spending for tobacco education, most states are not living up to their promises under the 1998 multi-state tobacco settlement, and/or are primarily focused on cigarette use and not "smokeless" products.

It will take several years for current trends to be assessed, but the need for ongoing prevention and cessation efforts cannot be understated in the face of continued, aggressive marketing by the smokeless tobacco industry.[13]

Grades are based on the percentage of high school males reporting spit or "smokeless" tobacco use in the past 30 days.

A	0 %
B	1-7%
C	8-14%
D	15-20%
F	21% or more
NA	Not Available=state did not participate in the 2005 YRBSS

B. Smokeless Tobacco Excise Taxes[14]

The United States earns a dismal "D" for spit tobacco excise taxes despite individual state improvement since Oral Health America's last report card in 2003. Of the states, only Massachusetts gets an "A" for the percentage citizens are taxed in purchasing spit tobacco products: 90 percent of wholesale price. Three states: Georgia, Kentucky, and Virginia get extra credit for adding a spit tobacco tax at all—bringing spit tobacco into the fold of tobacco products taxed at the state level. Others: Arkansas, Colorado, Maine, Michigan, Minnesota, Montana, Oklahoma, and Rhode Island increased the percent tax on manufacturer's or wholesale price. Connecticut earns special kudos for switching its spit tobacco tax from a price per ounce to percentage of the wholesale price. Finally, while Alabama and Arizona both increased the tax, they still get "no grade" for taxing by ounce instead of by wholesale price.

To some extent, all states with spit tobacco taxes deserve recognition. This smart move will yield increased revenues, reduce youth tobacco use, and help states avoid serious public health problems.[15] Additionally, it signals to users that spit and smokeless

[12] National Institute on Drug Use. *Monitoring the Future*. pp. 38-39.
[13] Ibid. Trends in Smokeless Tobacco Use Among Adults and Adolescents in the United States.
[14] Source: www.tobaccofreekids.org/research/factsheets/pdf/0169.pdf
[15] Campaign for Tobacco Free Kids. Fact Sheet: Benefits from Increasing Smokeless Tobacco Tax Rates, February 16, 2006. (http://www.tobaccofreekids.org/research/factsheets/index.php?CategoryID=33)

tobacco products are not different from smoking in that both can cause significant health problems.

Spit tobacco taxes are comparatively low. A whopping 31 states—over half—have spit tobacco taxes that are less than 40 percent of wholesale or manufacturer's price, earning them "D" or "F" grades. Only the District of Columbia and Pennsylvania are without spit tobacco taxes, for automatic "F" grades.

Studies have shown that when cigarette taxes are raised without a significant corresponding increase in smokeless tobacco taxes, users, especially young people, may switch to spit or "smokeless" tobacco rather than giving up nicotine entirely.[16] Further, Oral Health America encourages states to impose "smokeless" tobacco taxes based on wholesale or manufacturer's price rather than weight. Taxes based on wholesale price increase with inflation, while taxes based on weight reduce state tax on premium brands favored by youth.[17]

Grades are based on the percentage of wholesale or manufacturer's price for spit or "smokeless" tobacco products.

A	90% or more of wholesale or manufacturer's price
B	65-89% of wholesale or manufacturer's price
C	40-64% of wholesale or manufacturer's price
D	20-39% of wholesale or manufacturer's price
F	Less than 20% of wholesale or manufacturer's price
NG	No Grade=state tax is based on weight and not price (see above)

[16] Chalupka F, Warner K. Econometric studies of the demand for other tobacco products. *Economics of Smoking*: 36-37, January 12, 1999.
[17] Campaign for Tobacco Free Kids. Factsheet; Benefits from Increasing Smokeless Tobacco Tax Rates.

THE GRADES

State	Spit Tobacco Use	Excise Tax
Alabama	F	NG
Alaska	NA	B
Arizona	NA	NG
Arkansas	F	D
California	NA	C
Colorado	D	C
Connecticut	NA	D
Delaware	C	F
D.C.	NA	F
Florida	C	D
Georgia	C	F
Hawaii	NA	C
Idaho	D	C
Illinois	NA	F
Indiana	D	F
Iowa	D	D
Kansas	D	F
Kentucky	F	F
Louisiana	NA	D
Maine	C	B
Maryland	B	F
Massachusetts	C	A
Michigan	C	D
Minnesota	NA	B
Mississippi	NA	F
Missouri	C	F
Montana	F	C
Nebraska	D	F
Nevada	C	D
New Hampshire	C	F
New Jersey	B	D
New Mexico	D	D
New York	B	D
North Carolina	NA	F
North Dakota	D	NG
Ohio	C	F
Oklahoma	D	C
Oregon	NA	B
Pennsylvania	NA	F
Rhode Island	B	C
South Carolina	D	F

South Dakota	D	F
Tennessee	F	F
Texas	C	D
Utah	B	D
Vermont	C	C
Virginia	NA	F
Washington	NA	B
West Virginia	F	F
Wisconsin	C	D
Wyoming	F	D
United States	D	D

Methodology/Background

As sources for the grades in this report, Oral Health America used data sets from the national Youth Risk Behavior Survey, which monitors priority health risk behaviors that contribute to the leading causes of death, disability, and social problems among youth and adults in the United States. Background for the report was provided by the Monitoring the Future Survey, and from the Campaign for Tobacco Free Kids' online fact sheets.

Oral Health America has graded states on indicators affecting oral health status and overall well being through multiple report cards since 2000. Oral Health America is the premier, independent advocacy organization dedicated to improving oral health for all Americans. Founded in 1994 with former Major League Baseball player and sports broadcaster Joe Garagiola, Oral Health America's National Spit Tobacco Education Program educates people, especially young people, about the dangers of spit tobacco use. More information is at www.oralhealthamerica.org and www.nstep.org.

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