

# **Tobacco Control: A Blue Chip Investment in Public Health**

*The economic case and a detailed proposal for greater investment in  
tobacco control in Australia*

## **SECTION 6**

**Attachment 2**

**Section 1 – Cover, Contents, Preamble, Executive Summary, Chapter 2**

**Section 2 – Chapters 3, 4 and 5**

**Section 3 – Chapters 6, 7, 8, 9 and 10**

**Section 4 – References**

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## ***Attachment 2: Rationale, communication objectives and messages for national anti-smoking media education***

### ***A2.1 Background***

What would it take to ensure that as many Australians as possible were fully informed about the negative consequences of tobacco smoking? Anti-smoking campaigns need to assist all Australians to:

1. make an informed choice about smoking
2. access effective help to quit and
3. protect their dependents from exposure to environmental tobacco smoke (ETS) and inducements to take up smoking.

To achieve this people need to understand:

- all of the major health risks associated with smoking
- the addictiveness of tobacco-delivered nicotine
- the tactics that have been employed by tobacco companies to glamourise and normalise smoking and to minimise or divert attention from health risks
- the relative harmfulness of reduced-risk products
- the benefits of quitting
- behavioural strategies that maximise success in quitting
- pharmaceutical treatments that maximise success in quitting (to be paid for by pharmaceutical companies)
- resources and services available to people wanting to quit
- the dangers of exposure to ETS and strategies to avoid involuntary exposure to ETS
- procedures to report apparent breaches of tobacco control manufacture, marketing or retail regulations.

What kind of marketing effort would be required to ensure that all of the relevant target groups were reached within, say, six years or two terms of government?



## **A2.2 Target groups**

Target groups for the education program would include, for both rural and urban dwellers, in all States and Territories:

1. established smokers, of all ages,<sup>3</sup> of all SES groups,<sup>4</sup> at each of the stages that smokers have been demonstrated to go through during the quitting process [4]:
  - pre-contemplation,
  - contemplation,
  - preparation
  - action and
  - maintenance aiming both to prompt action and prevent relapse and including
    - those leading up to a first quit attempt and
    - those who have tried to quit many times before
2. young people currently experimenting with smoking
3. young people who are already regularly smoking, at various stages of smoking uptake
4. those not proficient in English
5. indigenous Australians
6. people who do not have access to telephones or the Internet
7. health professionals including doctors, nurses, health sector managers and administrators
8. intending, expectant and current parents
9. people suffering particular chronic diseases or conditions made worse by smoking or exposure to ETS (specifically adults with asthma; children with asthma and their parents; people with diabetes, cardiovascular disease and chronic obstructive pulmonary disease)
10. members of the public concerned about exposure to ETS
11. members of the public concerned about inducements to children to take up smoking.

## **A2.3 Communication objectives**

An anti-smoking media education program must be

- comprehensive and coherent
- compelling
- pervasive
- credible.

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3. Almost 70% of all smokers are aged between 18 and 45 years; around 28% of all smokers are aged 25 to 34 years. [1] However, it is among smokers 35 to 64 years that the earliest reductions in premature deaths will be avoided [2]. Therefore smokers of all ages need to be targeted.

4. While smoking rates among blue-collar groups are double smoking rates among white-collar groups (28.6 % compared to 14.5% [3]), around 35% of all smokers are in lower income white-collar groups [1]. Advertising and other media education must be designed to reach a very wide range of demographic groups.

The program must be supported by both public and private sectors to ensure that the appropriate package of assistance is available when smokers are ready to use it.

## **1. Comprehensive and coherent**

To be fully informed about smoking is more than just knowing that it causes lung cancer. To believe and understand all of the associated risks, and to appreciate the consequences of suffering a smoking-related disease, potential and current smokers need a great deal of information, including information of a complex scientific and statistical nature. This includes:

- the mechanisms by which tobacco smoke alters biological processes
- the magnitude of the risks they face
- the nature of all the major risks they face
- the consequences of smoking-induced illnesses on their day-to-day life
- the consequences to people, particularly families, of the disability or early death of a parent, spouse, child or friend.
- the reality that most if not all of the perceived benefits of smoking are transitory and are largely achievable in other, safer ways
- the fact that, while not easy, it is possible to quit successfully and improve the quality of their day to day lives as well as reduce their risk of disease in the longer term.

Advertisements and other media education tools must use clear simple language. Graphic and lifelike rendering of biological effects would be useful in some materials; in others it would be appropriate to use strong emotional arguments, appealing to smokers in a range of life situations.

## **2. Compelling**

Anti-smoking education takes place against the backdrop of both the addictiveness of the product and the long-standing and still pervasive promotion of smoking, particularly in youth culture.

Properly explaining the consequences of early death or prolonged disability and making this relevant to young people who have never had a doubt about their own mortality is particularly challenging.

Anti-smoking advertising and other media education will need to be compelling enough to enable people to:

- deconstruct the glamour of smoking created by years of advertising and pro-smoking media imagery
- let go of the various rationalisations that prevent action to quit
- persist through the difficulties of quitting an addictive product/habit.

In their evaluation of the large number of advertisements used in the US\$6 to \$10 per head per annum tobacco control program in the US state of Massachusetts, Biener and others have found that advertisements eliciting strong negative emotions were by far the most effective [5].

## **3. Pervasive**

Persuading people to attempt to quit is relatively easy. Much more challenging is staying tobacco-free. Advertisements need to be on air all year long, so that people maintain their resolve and resist pressures to relapse. In this way, peoples' initial investment in quitting – both the smoker's investment, and the community's is not wasted.



Pharmaceutical company research indicates that people quit in a cyclical pattern over approximately a 12-week period [6]. Ideally, each type of message would be seen by each smoker at least once throughout their quitting process. This requires advertisements aimed at people in each stage of the quitting process to be on air almost constantly.

## 4. Credible

It is crucial that all material presented to smokers is **credible** enough for smokers not to dismiss or exempt themselves from it. This requires information to be clearly explained and backed up with consistent messages from credible scientific and medical sources.

### A2.4 Specific messages<sup>5</sup>

#### 1. Health risks – for Target groups 1 to 6

Over a three-year period a very large amount of material would need to be covered, including:

1. Substances in tobacco smoke and how these damage the lungs, heart and the genes

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*There are more than 4,000 chemicals in tobacco smoke, including carbon monoxide, nicotine, formaldehyde, ammonia, and 43 chemicals known to be human carcinogens, that is, cancer causing substances [7].*

*Carcinogens and carcinogenic metabolites travel beyond the lungs into the bloodstream and damage genes of cells in the lungs and numerous other body organs [8].*

*Cigarette smoking also contributes to cardiovascular disease in at least three ways, mainly through the effects of carbon monoxide and nicotine: 1. by accelerating heart rate and blood pressure, making the heart work harder for less oxygen, eventually leading to myocardial dysfunction; 2. by aggravating and accelerating the development of atherosclerotic lesions, thereby narrowing arteries and increasing the risk of rupture; and 3. increasing insulin resistance [9].*

*Smoking interferes with the body's methods of filtering inhaled air. Chemicals such as hydrogen cyanide, ammonia and formaldehyde have a direct deleterious effect on the lung cilia, leading to an accumulation of mucus and toxic agents. Over secretion of mucus, airway thickening and narrowing and damage to the small airways combine to reduce lung function, a condition known as chronic obstructive pulmonary disease [10].*

2. The enormity of the risk faced.

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*Nine out of ten smokers suffer at least the beginnings of Chronic Obstructive Lung Disease (COLD).*

*One in two smokers die early due to smoking; half in middle age.*

3. What it **really** means to have lung cancer, or COLD.

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*Survival rates for lung cancer is less than one in ten.*

*Increasingly younger women, including mothers of young children, are dying of lung cancer.*

*Suffering from COLD is like drowning in slow motion.*

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5. The following boxes contain preliminary ideas for educational materials. In each case, ideas need to be market-tested to guide framing, emphasis and presentation.

4. The link between smoking and heart disease and stroke.

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*Smokers are much more likely to have heart attacks, to die before they get treatment and to die young; the emotional and economic consequences for families of losing a parent in their most productive and responsible years.*

*The incidence of stroke is much higher among smokers, even in young women and men, often resulting in long-term disablement.*

*Nine out of ten patients with peripheral vascular disease are smokers. This condition often requires amputation of limbs.*

5. Some of the very nasty but lesser known risks.

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*Cancer of the lip, oesophagus, stomach, penis, vulva, anus, bladder.*

6. The many very disabling conditions that smoking makes worse or increases the risk of, such as:

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*Osteoporosis, diabetes, asthma, macular degeneration, hearing loss.*

7. Some of the special problems relevant to intending expectant and new parents.

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*The risk of still-birth, SIDS and growth retardation.*

## **2. Addictiveness of tobacco-delivered nicotine – Target groups 1 to 7**

Smokers and potential smokers need to understand:

1. The effect of nicotine on the brain, and in particular on developing brains resulting in long-term, possibly permanent, changes in brain systems.
2. The engineering of tobacco products – to maximise speed and intensity of delivery to the brain.
3. If we have started smoking, what we can do to reduce our chances of becoming addicted.
4. The situational nature of most addiction and what we can do to prevent becoming dependent.

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*“Avoid the draw-back.”*

*“Smoke on a schedule rather than when and where you feel you need to.”*

*“Stop Smoking!”*

## **3. Strategies employed by tobacco companies to glamourise and normalise smoking**

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*Marketing strategies to divert people from thinking about health.*

*Research and lobby group funding and PR to delay introduction of smoking bans.*

*Promotion of smoking through Hollywood movies and other aspects of popular culture.*

## **4. Relative harmfulness of reduced-risk products – for Target groups 1 to 7**

1. The myth of low tar cigarettes

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*Ventilation holes.*

*Deeper inhalation causing cancers that are even harder to treat.*



2. Behind the marketing hype of reduced-risk products

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*The facts about ...*

*Whatever comes on to the market*

*... So-called reduced risk cigarettes*

*... Low-nicotine cigarettes*

3. How the industry manipulates tar levels as measured, etc

**5. The benefits of quitting – for Target groups 1 to 7**

1. The financial benefits of quitting

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*What you could save – equivalent to a \$50 a week pay rise, and*

*What you could buy*

*How much quicker you could get together a deposit for a house or pay off a mortgage*

2. The benefits for people who are thinking of starting a family

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*Improved virility and fertility, greatly lowered risk of growth retardation, premature birth and stillbirth, and lower risk of SIDS*

3. The benefits for your children

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*How much more financial support you could give to your kids; less coughs and colds, better school performance; lower likelihood of kids taking up smoking and, possibly even other drugs as well.*

4. The immediate and long-term improvement in quality of life

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*The return of the pleasures of taste and smell*

*The increase in energy enjoyed when you replace cigarettes with safer and often more effective strategies for dealing with situations where smoking was used as a prop*

**6. Behavioural strategies that maximise quitting, for Target groups 1 to 7, encourage use of help and dispell myths which will lead you to doing it in some way when you are not really ready**

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*“Set a quit date and psych yourself up for it; Rubber band onto your cigarette pack.a photo of your kids or a list of the reasons you want to quit”, etc – Probably a set of about ten tips.*

**7. Pharmacological treatments – for Target groups 1 to 7**

1. NRT and Zyban cannot work without the application of personal effort and work more effectively when combined with advice on new ways of dealing with situations.

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*Using some sort of pharmacotherapy will increase your chance of success. These are safe and effective if used as recommended, as part of comprehensive treatment.*

*Don't make the mistake of thinking these are a magic bullet. Use them to help you. Don't expect them to do it for you.*

## **8. Resources and services – for Target groups 1 to 7**

The Quitline

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*What it does and does not do, and how to contact it – phone number.*

Finding out about other services

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*Internet addresses.*

Neighbourhood services

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*Local courses and groups.*

## **9. Dangers of ETS – for Target groups 1 to 10**

1. What is in ETS?
2. What ETS exposure can do to people both in the short and long term
3. The impossibility of knowing if someone is asthmatic or suffering from undiagnosed heart disease
4. Effective and ineffective strategies for protecting those around you.

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*Practical tips for reducing the exposure of your children if you have not yet given up (effective [6] – going outside, well away from your children; possibly reasonably effective – standing beside stove, with kitchen door closed, under very strong stove exhaust fan; probably not effective – blowing smoke in opposite direction or above someone's head; smoking near an open window).*

## **10. Reporting procedures – for Target groups 7 to 11**

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*What you should do if you know of retailers selling to children.*

*What to do if someone smokes in a public place.*

### **A.2.5 Media**

#### **Media selection**

Media selection needs to be appropriate to:

- the complexity of the message to be conveyed
- the dramatic value of the material and
- the target group.

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6. As determined by research.



## Media message matrix

Media includes:

- mass media such as TV, radio, print (general, youth and women's and men's magazines), cinema and outdoor advertising
- "new media" including internet, websites and chat-rooms, SMS messaging and interactive TV
- media in languages other than English (TV, radio and print)
- Aboriginal and Torres Straight Islander people's media
- medical media (including General Practice magazines)
- other specialist media including:
  - pregnancy magazines, doctors TV
  - parenting magazines such as *Melbourne Child* (Messages 5.1, 5.3 above)
  - newsletters for sufferers of chronic diseases and websites dedicated to their concerns (Messages 1.6, 2, 4, 5, 6, 7, 8, 9)
  - hospitality industry trade press and websites (Message 9)
  - publications aimed at small business (Message 9)
  - health insurance company member newsletters and websites (Messages 1.1 to 1.6, 2, 4, 5, 6, 7, 8, 9)
  - parent organisation and teacher, and school principal newsletters (Message 3.3)
  - newsletters and websites of the Film Finance Corporation and similar film and arts financing bodies (Message 4).
- grants to local service providers to promote services
- point-of-sale advertisements in pharmacies, in outlets where tobacco is sold, and in other selected retail outlets
- promotional items in selected social venues where smoking is currently prominent, for instance in hotels, night-clubs, public – toilet doors, coasters, post cards etc
- tobacco package inserts and pack warnings (costs to be covered by tobacco companies).

## Frequency-exposure

An ongoing, high-reach, high-intensity counter advertising campaign is required:

- On air at least 48 weeks of the year, to reach people at multiple times, at all stages in their quitting process
- With more intensive campaigns during periods when many people make quit attempts, such as at New Year, World No Tobacco Day, at the end of Winter, and for several months afterwards when they tend to relapse.

## **A2.6 Public relations support**

Every day throughout the world, results of studies are published confirming or raising the possibility of some new disease caused by smoking. Other studies provide insights into the processes of smoking uptake and cessation. Media coverage about such research has always been an important means by which the public has become informed about the dangers of smoking. However, the studies are becoming increasingly technical, and are not always drawn to media attention. With just a little additional work to make it relevant to the Australian context, national health groups could provide spokespeople and encourage Australian media to do stories about such research. This and other stories about uptake, cessation and harm reduction research would greatly amplify the impact of paid advertising, both in terms of awareness and credibility.

It is proposed that an Anti-Tobacco Media Liaison person would be employed in each major health organisation (as described in the following 'Budget' section).

The media liaison person would track international research relevant to tobacco and their organisation, undertake communication and education activities with members, donors etc including the specialist media; liaise with experts and investigators engaged in such research in Australia, and promote them to journalists as suitable spokespeople; organise reports launches and events that could be promoted in the media; alert mass media journalists to international research that may be of interest to Australian readers, listeners and viewers.

## **A2.7 Evaluation**

With such a significant investment, it is critical that we maximise benefits and demonstrate to the community the extent to which it achieves the campaign its aims. We propose continuously tracking the campaign with at least two contacts with each survey respondent to allow us to assess the short-term impact of different elements of the campaign. This information will need to be fed back continually into the creative side to ensure that new executions build on successes, and address barriers and issues that emerge. To achieve this will also require ongoing qualitative work with key subgroups for target groups. The research and evaluation team should be involved in all aspects of campaign design and delivery to ensure that the material produced and disseminated is based on the best available evidence and that the campaign is modified to take into account the changes that occur within the community as a result of the campaign.



**Message/Medium Matrix**

	<b>1. Health risks</b>	<b>2. Addictive TDN</b>	<b>3. De- bunk</b>	<b>4. PERP</b>	<b>5. Quit benefits</b>	<b>6. Quit tips</b>	<b>7. TDTs</b>	<b>8. Services and resources</b>	<b>9. ETS dangers and avoid</b>	<b>10. Report</b>
<b>TV</b>	1 to 6–18 TVCs	1 TVC		2 TVCs	2 TVCs	10 TVCs	1 TVC	8.1 3 TVCs	9.1 to 9.4 3 TVCs	
<b>Radio</b>				X	X	20	X	X	X	X
<b>Cinema</b>	Maybe 3		<b>X</b>							
<b>Outdoor</b> Transport shelters Ambient media	5				X				X	
<b>Print</b> General news Women mags Youth	6									X
<b>New media</b> Internet websites and chat rooms SMS messaging Interactive TV	5	1, 2, 3	<b>X</b>	X	X	X	X	X	X	
<b>Ethnic</b>	X	X		15	30	150	X	X	X	X
<b>ATSI</b>				X	X	X	X	X	X	X
<b>GP media</b>						X	X	X		X
<b>Specialist media</b>	Partic 4 & 6	X	X		X	X	X	X	X	X
<b>Grants to comm orgs for local promotion</b>						X	X	X		X
<b>Point of sale advertising</b>	1 to 6							X		
<b>Promotional items in pubs, clubs</b>									X	
<b>Package inserts, pack warnings</b>	1 to 6	1,2,3								

## A2.8 Budget

### Creative production

The communication challenge will require advertisements and media material of greater production value than the majority so far produced in Australia on the very limited budgets available.

While the dramatic execution may not be identical, the number, quality and frequency of traffic accident prevention advertising in the state of Victoria provide a guide to the sort of budget that might be required.

### Public relations support

Allocations for a Anti-Tobacco Media Liaison person to be employed at the

- Australian Cancer Society – \$90,000
  - the Heart Foundation – \$90,000
  - the Thoracic Society – \$75,000
  - Asthma Australia – \$45,000
  - the SIDS Foundation – \$25,000
  - ASH Australia, to cover all other disease risks and more general issues, and -play a major coordinating role – \$120,000
  - a consortium of the cancer behaviour research centres – \$80,000
  - a consortium of public health/public policy research centres – \$80,000
  - communication, information sharing and annual meetings – \$10,000
- Total: \$615,000

Health organisations would provide on-costs and additional funding towards advocacy.

#### Cost of media liaison staff for each Quit Campaign

State	Existing (est)	Extra needed
NSW	\$0	\$80,000
Vic	\$70,000	\$10,000
Qld	\$10,000	\$70,000
WA	\$35,000	\$45,000
SA	\$35,000	\$45,000
Tas	\$0	\$60,000
ACT, NT	\$0	\$120,000



## Media Screening

A budget of at least \$40m per annum would be required to purchase time/space in appropriate media at levels sufficient to ensure awareness and prompt action among all target groups.

## Administration

Marketing director (1) – \$150,000

Adult smoker, Youth and Specialist program “product” managers – \$125,000; \$90,000; \$100,000

Marketing coordinators – 2 @\$40,000 each

PR Director with a personal assistant – \$130,000

## Evaluation

The budget for development of resources (advertisements etc) will include funding for qualitative testing. To survey 400 people per week (half of whom are smokers) and to re-interview as many of the smokers as possible again 2–3 weeks later, to assess short-term impacts on smokers with more power will cost around \$825,000 per year, with staff costs and extras would cost about \$1.2m. This would be the centre-piece and allow for most needs. Combined over periods, it will allow study of all major subgroups. However, for smaller and hard-to-reach subgroups, focussed studies will be needed. These include Aboriginal peoples and Torres Strait Islanders, speakers of languages other than English at home, and people without telephones (for instance those in unstable housing and those with major disabilities). A total of \$1.5m would be required for evaluation of media education and related strategies. A further \$1.5m for evaluation of the tobacco control program as a whole is provided in Program 3 – refer to Section 7.3.

## Funding sources

Funding sources would include

- the Federal Government – the core program of mass media advertising to achieve messages 1 to 7 (section A2.4 above)
- State and Territory Government – additional health-related advertising (messages 1 to 7), plus advertising to cover messages 8 to 10 (section A2.4 above)
- pharmaceutical companies – direct promotion of pharmaceutical treatments; a levy on sale of pharmaceutical products to cover generic promotion of pharmacological treatment
- health groups – to cover advocacy and media education about the links between smoking and particular diseases
- the tobacco industry – package warnings and inserts.

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7. For use over the first three years, with most successful ones to be repeated over the following 6 to 9 years.

	2002-03 to 2004-5			Federal as % of total
	Federal \$M	State \$M	Total \$M	
<b>Ten target groups</b>				
<b>1. Total population education</b>				
<b>Media production including development costs</b>				
36 TVCs over 6 years, <sup>7</sup> @ av \$350,000 per TVC	4.2		4.2	
27 radio adverts over next 6 years @\$5,000 each	0.25	0.2	0.45	
Outdoor advertising	0.25		0.25	
Print advertisements, 21	0.1	0.25	0.35	
<b>Media screening – total</b>	<b>20</b>	<b>12</b>	<b>32</b>	
<b>2. Young people experimenting</b>				
<b>Media production</b>				
Cinema	0.35		0.35	
TV advertorials	0.25		0.25	
<b>Media screening – total</b>	<b>1</b>	<b>0.5</b>	<b>1.5</b>	
<b>3. Young adults already smoking</b>				
<b>Media production</b>				
Cinema	0.35		0.35	
Radio and Print advertorials	0.25		0.25	
Promotional items	0.5		0.5	
SMS messaging, Interactive TV				
<b>Media screening – total</b>	<b>4.05</b>	<b>2</b>	<b>6.05</b>	
<b>4. Ethnic media</b>				
<b>Media production</b>				
TV language dubbings	0.25		0.25	
Radio, 18 in 12 languages	0.36		0.36	
Print, 21 in 9 languages	0.32		0.32	
<b>Media screening – total</b>	<b>1.5</b>	<b>0.41</b>	<b>1.91</b>	
<b>5. ATSI media</b>	<b>0.25</b>	<b>0.1</b>	<b>0.35</b>	
<b>6. Grants for local and community media</b>		<b>0.25</b>	<b>0.25</b>	
<b>7. Health professional education</b>	<b>1</b>		<b>1.0</b>	
<b>8. Parent education</b>	<b>0.75</b>	<b>0.075</b>	<b>0.83</b>	
<b>9. Chronic disease sufferers</b>	<b>0.25</b>	<b>0.05</b>	<b>0.30</b>	
<b>10. Concerned public</b>		<b>0.5</b>	<b>0.50</b>	



PR support across all programs	1	2	3.00	
Media commission @ 15%	4.35	1.94	5.29	
Marketing director, managers and admin staff	0.65		0.65	
Media monitoring and impact evaluation	1.5		1.5	
<b>Total</b>	<b>\$43.73</b>	\$20.28	<b>\$64.00</b>	68%

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