EXHIBIT 5
DATE 1/26/2010
HB

Mr Chairman, Members of the Committee, Thank you for your time this morning. My name is Robert Shepard. I am a physician here in Helena. I was in private practice for 26 years. I now work part time at New West Health Services. I am a current member of the Tobacco Use Prevention Advisory Council and I was a member and chairman of the original Advisory Council. Today, I am here as a private citizen and my remarks do not represent either my employer or the Council.

I have been involved in Tobacco prevention efforts for 20 years. In the beginning, I was often asked to provider Montana specific data on the success of the program. At the time, the program was either just a vision, or too young to have any data. Nonetheless, we answered confidently that the program would indeed reduce the use of tobacco in Montana. This confidence was based on the well researched effectiveness of tobacco use prevention program around the country. These programs were analyzed and reported on by the CDC, resulting in an extensive set of best practices. We didn't have reinvent the wheel. How to do this was well known.

Tobacco use prevention rests on three pillars: Increasing tobacco taxes, Smokefree indoor air laws, and Prevention education along with cessation education. According to the CDC, using all three pillars increases the effectiveness of the program. Using only one pillar may work, but less effectively than the three together. This conclusion was derived from the study of many programs across the United States implementing all or parts of a comprehensive program.

We can now confidently report that the program in Montana has been very successful. Youth smoking prevalence has dropped from 27% in 2000 to 15% in 2009. Adult smoking has reduced from 22% in 1999 to 19% in 2009. To those who might argue that only the cigarette tax has worked, I would point out that these rates started dropping well before the tobacco tax increase in 2005. Moreover, while tobacco taxes are unquestionably effective in reducing smoking in both adults and youth, they tend to diminish over time as people adapt to the price. It would ideal to increase the tax again as a matter of public policy.

The quit line has been very successful. The overall long term (1 year) quit rate is about 30% making our quit line one of the top five quit lines in the country. They can offer very cost effective counseling which is very helpful in increasing the effectiveness of the program. This counseling is very useful to busy physicians who rarely have time to do this themselves.

We can look to the effects of reducing or eliminating tobacco use prevention programs. While Montana has been fortunate in not performing this experiment on its citizens, other states under various budget and policy pressures have reduced or eliminated their tobacco use prevention programs. In doing so, the tobacco use rates have gone back up again. We know with certainty that that will happen here if we cut this program.

We also know that these programs reduce disease. Since the Helena study ~~four~~ Six years ago documenting a rapid and dramatic drop in heart attacks after the smoke free ordinance in Helena, these results have been 13 times around the world, and over longer periods of time as well as much larger populations. Smoke free laws also have important impacts on tobacco use, typically reducing the use of tobacco by 5-10%. The final stage of our Clean Indoor Air Act occurred in 2009 and we should begin to see the impact when we get to 2010 tobacco use data.

This program is effective and will continue to produce long term benefits to our population and I urge you to continue it current great progress.

Thank you for your time this morning. I have another obligation and will need to leave about 9:30. I will be happy to answer any question until then.

Respectfully,

Robert M Shepard, M.D.