Progress and Opportunities in Tobacco Control

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ABSTRACT Much progress has been made in reducing tobacco use in the United States. Despite the continuing challenges of tobacco control and the massive burden of illness, death, and economic costs caused by tobacco products, there are now unprecedented opportunities to prevent and treat tobacco dependence through a combination of interventions that have proven effective at both the population and individual levels. This report briefly reviews population trends in tobacco use by youth and adults, describes some of the policy measures that have proven effective in comprehensive tobacco control, and discusses the role of clinicians in the diagnosis and treatment of tobacco dependence in patients. (CA Cancer J Clin 2006;56: 135–142.) © American Cancer Society, Inc., 2006.

INTRODUCTION

Much progress has been made in reducing tobacco use in the United States. Per capita cigarette consumption has decreased to its lowest level since World War II.¹ The percentage of adults who currently smoke cigarettes dropped to 21% (23.4% in men, 18.5% in women) in 2004; the percentage of high-school students who smoked in the past month decreased from 36% in 1997 to 22% in 2003.² Nevertheless, 44.5 million US adults and 3 million adolescents (12 to 17 years old) still smoke.³,⁴ Half of all Americans who continue to smoke will die from their addiction to cigarettes.⁵ In the United States, tobacco use is responsible for nearly 1 in 5 deaths, amounting to approximately 438,000 premature deaths annually and 30% of all cancer deaths.⁶,⁷

Despite the continuing challenges of tobacco control and the massive burden of illness, death, and economic costs associated with tobacco products,⁸,⁹ there are now unprecedented opportunities to prevent and treat tobacco dependence through a combination of interventions that have proven effective at both the population and individual levels.⁸,⁹ Policy measures such as increasing tobacco excise taxes, implementing smoke-free laws to protect the health of nonsmokers from secondhand smoke, and counteradvertising to deglamorize smoking are effective in reducing initiation of tobacco use by children and motivating addicted smokers to quit.⁸,⁹ At the same time, improvements in treatment of tobacco dependence provide smokers and their doctors with more options to individualize cessation therapy.¹⁰,¹¹ This report briefly reviews population trends in tobacco use by youth and adults, describes some of the policy measures that have proven effective in comprehensive tobacco control, and discusses the role of clinicians in the diagnosis and treatment of tobacco dependence in individual patients.

PATTERNS OF SMOKING IN YOUTH

National trends in the prevalence of current smoking in youth have been measured annually since 1976 in 12th-grade students and since 1991 in 8th- and 10th-grade students by the Monitoring the Future Survey conducted by the University of Michigan. Among 12th-grade students, the prevalence of smoking decreased from 39% in 1976 to 29% in 1990.¹² In all three grades, smoking prevalence increased from 1991 to 1996 (Figure 1) due to intensified...
promotion efforts directed toward youth by the tobacco companies.13–15 Since 1996 for 8th and 10th graders and since 1997 for 12th graders, smoking prevalence has decreased in all groups (Figure 1). The percentage decrease since the peak year was 56% in 8th graders, 47% in 10th graders, and 32% in 12th graders. The declines coincided with an increase in tobacco-control efforts, including higher excise taxes on cigarettes and counteradvertising directed to adolescents in some states.16–18 It is noteworthy, however, that these declines in youth smoking have decelerated sharply between 2003 and 2005, coinciding with cutbacks in funding for tobacco control.19 Patterns of adolescent smoking also differ by race and ethnicity. According to results from the National Youth Tobacco Survey conducted in 2004, the prevalence of smoking among high-school students was 24.5% among American Indian/Alaska Natives, 24.8% among non-Hispanic Whites, 20.5% among Hispanic/Latinos, 11.0% among African Americans, and 11.3% among Asians.20

PATTERNS OF SMOKING IN ADULTS

According to data from the National Health Interview Surveys,21 the smoking prevalence in men and women age 18 years and older decreased markedly during the second half of the 20th century. Between 1965 and 2004, the adult smoking prevalence decreased from 42.4% to 21%, although the rate of decrease has slowed since 1997 (Figure 2). Trends in smoking differ by gender and education. The prevalence of current smoking remains higher in males (23.4%) than females (18.5%), although the gender gap has narrowed over time.2 In contrast, the socioeconomic gradient in smoking has widened.21 For example, smoking prevalence among adults with less than a high-school degree declined from 41.7% in 1965 to 29.7% in 2004, whereas that among college graduates dropped from 35% to 10% during this period.21 Adult smoking prevalence also varies widely by race and ethnicity. In 2004, the prevalence of cigarette smoking in persons age 18 and older was 33.4% among American Indians/Alaska Natives, 22.2% among non-Hispanic Whites, 20.2% among African Americans, 15.0% among Hispanics/Latinos, and 11.3% among Asians.3

POLICY MEASURES IN TOBACCO CONTROL

Excise Taxes

Increasing the price of cigarettes through excise taxes is one of the most effective ways to reduce tobacco consumption.8,22–24 Excise taxes on cigarettes serve the dual purpose of reducing tobacco consumption and providing revenues to fund comprehensive tobacco-control programs.8,9 The impact of excise taxes is greatest on young people.8,25 Even though state excise taxes on cigarettes have increased over time, the tax remains low in most states. In 2005, the average state cigarette tax was $0.917 per pack, with an additional $0.39 per pack federal cigarette tax. The state cigarette excise tax varies widely across
States, from $0.07 per pack in South Carolina to $2.46 per pack in Rhode Island (Figure 3). Thirty-one states have a state cigarette excise tax of less than $1.00 per pack of cigarettes, and 15 of these states have excise taxes less than $0.55. States with low taxes are mostly concentrated in the Southeast and Central United States and include many of the tobacco-growing states. Forty-one states increased their cigarette taxes during the past 4 years. However, only 19 states have laws requiring that a portion of the excise tax be dedicated to tobacco-control or cancer programs.

Even though cigarette excise taxes have risen in the past few decades, the retail price of cigarettes has increased more rapidly to finance tobacco promotion. From 2000 to 2003, tobacco-industry marketing expenditures increased by $5.55 billion to $15.15 billion, more than a twofold increase since the Master Settlement Agreement with the states in 1998. By comparison, total expenditures for tobacco control decreased slightly from 2000 to 2003 (Figure 4). In 2003, for every dollar spent in the United States on tobacco-control efforts, the industry spent almost $23 to promote its products (Figure 4). Progress in tobacco control could be accelerated by substantial further increases in tobacco excise taxes and allocation of this revenue to tobacco-control programs.

Smoke-free Laws

The purpose of comprehensive smoke-free laws is to protect nonsmokers from secondhand smoke. Other benefits for such laws are to reduce the social acceptability of smoking, to deter the initiation of smoking by children, and to encourage smokers to cut back or quit. In 1964, there were no laws regulating smoking in schools, public transportation facilities, government buildings, restaurants, or bars. However, as the scientific evidence on the harmful health effects of secondhand smoke has accumulated, many state and local governments have enacted smoke-free legislation. Today, over 2,000 municipalities and 15 states (California, Connecticut, Delaware, Florida, Idaho, Massachusetts, Maine, Montana, North Dakota, New York, Rhode Island, South Dakota, Utah, Vermont, and Washington) have implemented some form of smoke-free legislation. Six states (Delaware, Maine, New Jersey, New York, Rhode Island, and Washington) and the District of Columbia have passed smoke-free laws that prohibit smoking in bars and restaurants as well as workplaces. For more details on this issue, see Cancer Prevention and Early Detection Facts & Figures.

In response to public support of smoke-free laws, tobacco lobbyists have encouraged state legislatures to pass preemption laws that prohibit local communities from enacting smoke-free laws that are more stringent than state laws. Nineteen states have some form of preemption law that pertains to government worksites, private-sector worksites, and/or restaurants. In contrast, states without preemptive provisions set minimum requirements for other legislation and, there-
Therefore, allow the passage and enforcement of stronger local smoke-free ordinances. Health advocates should oppose new preemption language in state laws and seek to repeal existing laws that limit local efforts to pass effective local smoke-free ordinances.

Smoking Cessation

Smoking cessation at any age can prevent much of the future risk of tobacco-related diseases. In 2004, an estimated 14.6 million (40.5%) adult smokers had stopped smoking for...
at least 1 day because they were trying to quit; however, about 5% are successful in quitting for at least 1 year. Clinicians play a critical role in encouraging smokers to quit and in providing or referring patients to appropriate counseling and treatment. The essential features of smoking cessation advice by health care providers are known as the 5 A’s: ask about tobacco use, advise to quit, assess willingness to make a quit attempt, assist in the quit attempt, and arrange timely follow up.

For most smokers, addiction to nicotine is a true drug dependence; like other addictions, it can be clinically managed with effective treatments. Therapies that are known to be effective for treating tobacco dependence include both pharmacological (eg, nicotine-replacement therapies and/or antidepressant therapy with bupropion or Wellbutrin) and behavioral treatments (eg, one-to-one or group behavioral counseling). Counseling may be as simple as advising a smoker to quit or as complex as using a computer to tailor the intervention to the individual smoker. Detailed information on these treatments can be found in the Tobacco Dependence Clinical Practice Guidelines.

Clinicians treating their patients for tobacco dependence may choose to refer their patients to telephone quitlines. The number of telephone quitlines has increased in recent years. Currently, 44 states have quitlines that provide information and counseling services to smokers who want to quit. In addition, quitline services are provided by federal and nonprofit organizations. Studies have shown that quitlines are effective in improving smoking cessation rates.

Tobacco dependence is a chronic, relapsing condition that often requires repeated clinical intervention. The typical smoker who quits does so after multiple unsuccessful attempts. Routine repeated advice, counseling, and support from a clinician or other health professional has been shown to increase the likelihood of successful quitting.

Government-sponsored policies that mandate or subsidize financial coverage of treatments for tobacco dependence can enhance access to appropriate treatments. Currently, publicly funded health insurance programs, such as Medicaid, provide full or some coverage for cessation treatments in most states, but no coverage in 11 states (Figure 5). Medicare’s new prescription drug benefit covers smoking cessation treatments prescribed by a physician. Private health plans, which cover working-age smokers, by and large do not cover treatment for tobacco dependence. One survey conducted in 2003 showed that only 17 states (out of 45 states surveyed) ensured that state employees had access to health insurance coverage for pharmacotherapy and counseling for tobacco cessation. A 2001 national survey of private employers revealed that only 20% of employers offered coverage for tobacco cessation. Uninsured or underinsured smokers have less access to tobacco-cessation treatments and are less likely to use effective treatments when attempting to quit smoking.

Treatment of tobacco dependence not only reduces morbidity and mortality, but it is also cost effective. State and national tobacco control policies must address the need to make effective treatment for tobacco dependence available to the widest possible groups of tobacco users.

OTHER APPROACHES TO TOBACCO CONTROL

Other aspects of comprehensive tobacco control are described in more detail in the American Cancer Society’s Cancer Prevention and Early Detection Facts & Figures and the Centers for Disease Control and Prevention (CDC)’s Best Practices for Tobacco Control Programs. Over the past decade, several states—including California, Massachusetts, Arizona, and Oregon—have implemented comprehensive tobacco-control programs supported by state cigarette excise taxes and/or other sources. Despite varying levels of funding, these programs have demonstrated greater success in reducing tobacco use than is possible without such programs. The CDC considers comprehensive state-based programs to be effective (and cost-effective) platforms that control tobacco use, achieve significant public health gains, and reduce the financial costs from smoking.
Counteradvertising is used by comprehensive tobacco-control programs to educate the public about the dangers of tobacco, counteract the marketing appeal of tobacco products, and change social norms about the acceptability of tobacco use. Mass-media campaigns can reduce the prevalence of smoking and are most effective when sustained and delivered as part of a comprehensive tobacco-control program.\textsuperscript{8,25,54}

Policies that restrict access of minors to tobacco products are widely supported by the public.\textsuperscript{8} Presently, most states prohibit tobacco sales to persons under the age of 18 years, and three states (Alabama, Alaska, and Utah) prohibit sales to persons under the age of 19 years. Only 20 states require retailers to demand verification of a patron’s age before selling a tobacco product.\textsuperscript{55} Bans on advertising and promotion of tobacco products are also helpful in regulating these harmful products and reducing smoking prevalence.\textsuperscript{8}

\textbf{FUNDING FOR TOBACCO CONTROL}

Currently, average funding for state tobacco-control programs is about one third that of the amount recommended by the CDC. Only four states (Colorado, Delaware, Maine, and Mississippi) meet or exceed the CDC Best Practices minimum level for funding in 2006. Funding for tobacco-prevention programs in 11 other states is at least half the minimum level recommended by the CDC, whereas the remaining states have tobacco-control funding levels less than half of the recommended...
amount. Compared with fiscal year 2001, the allocation for state tobacco-control programs has been reduced in 28 states.19,56,57 For more details, see the Cancer Prevention and Early Detection Facts & Figures.2

CONCLUSION

Reductions in tobacco use have great potential to prevent the approximately 30% of cancer deaths caused by smoking.7,58 Comprehensive state tobacco-control programs play a critical role in preventing the uptake of tobacco use by children, facilitating successful cessation, and protecting nonsmokers from secondhand smoke.8,9,22,29,59 Progress in reducing tobacco use can be accelerated by more systematic implementation of strategies that are known to be effective in preventing and treating tobacco dependence.

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