



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
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BEST PRACTICES FOR COMPREHENSIVE TOBACCO CONTROL PROGRAMS:
SUMMARY OF THE SCIENTIFIC EVIDENCE

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The Burden of Tobacco Use:

- Cigarette smoking and exposure to secondhand smoke are responsible for approximately 480,000 deaths each year in the United States—or about one in every five deaths—making smoking the single most preventable cause of death and disease in the United States.¹
- Since the publication of the first Surgeon General’s report on the health effects of smoking in 1964, cigarette smoking has been causally linked to diseases of nearly all organs of the body.¹
 - Even 50 years after this first report, research continues to identify new diseases caused by smoking, including common, painful diseases such as diabetes, rheumatoid arthritis, and colorectal cancer.¹
 - And since 1964, more than 20 million premature deaths in the United States can be attributed to cigarette smoking.¹
- The effects of smoking on health are profound. Smokers cut over 10 years off of their life expectancy, meaning they are likely to die 10 years earlier than if they had not started smoking.² Non-smokers are twice as likely to live to age 80 compared to smokers.² In other words, smoking is not just killing people at the end of their lives, but killing them in middle age.
- But the harmful effects of smoking do not end with the smoker. Secondhand smoke causes an estimated 34,000 heart disease deaths and 7,300 lung cancer deaths each year in nonsmoking adults.¹
 - In 2006, the Surgeon General concluded that there is no risk-free level of exposure to secondhand smoke.³
- In addition to this enormous health burden, smoking also imposes a major economic burden on society, costing the United States more than \$300 billion each year, including nearly \$170 billion for direct medical care of adults and more than \$156 billion from lost productivity (e.g., increased use of sick leave, etc.) due to premature death.^{1,4}

Best Practices for Comprehensive Tobacco Control Programs

- Chapter 15 of the 50th Anniversary Surgeon General’s report recommends enhancing implementation of proven tobacco-control strategies, including:
 - Fully funding statewide tobacco control programs at CDC-recommended levels.
 - Raising the average price of tobacco products, a policy intervention proven to prevent youth

- from starting to smoke and encourage smokers to quit.
 - Extending comprehensive smokefree indoor protections, which prohibit smoking in indoor worksites and public places, including restaurants and bars, to 100% of the U.S. population, a strategy proven to protect people from secondhand smoke, help decrease smoking rates, and help prevent youth smoking initiation.
 - Mass media campaigns that shape social norms around preventing tobacco use initiation, encouraging cessation among current users, and encouraging support for smoke-free environments.¹
- The Surgeon General recommended full funding for statewide comprehensive tobacco control programs at CDC-recommended levels because evidence-based state tobacco control programs that are comprehensive, sustained, and accountable have been shown to reduce smoking rates and tobacco-related disease and death.^{1,5}
- A comprehensive state tobacco control program is a coordinated effort to prevent initiation of tobacco use among youth and young adults, to promote quitting among adults and youth, to eliminate exposure to secondhand smoke, and to identify and eliminate tobacco-related disparities among population groups.⁵ This comprehensive approach optimizes synergy from a mix of educational, clinical, regulatory, economic, and social strategies.⁵
- States that have made larger investments in comprehensive tobacco control programs have seen larger declines in cigarette sales than the United States as a whole, and the prevalence of smoking among adults and youth has declined faster as spending for tobacco control programs has increased.^{6,7,8}
- *Best Practices for Comprehensive Tobacco Control Programs–2014* provides the specific recommended annual investment required to implement a comprehensive, effective tobacco control program in each state.
 - While all states combined currently receive about \$80 per person in revenue from tobacco settlement payments and sales each year, states’ actual spending on tobacco control is less than \$1.50 per person per year.⁵
 - This is only 15 percent of CDC’s national recommended annual investment from *Best Practices-2014*, which is \$10.53 per person.⁵
- These funding recommendations are small when compared to tobacco industry advertising and promotion.
 - Each day in the United States, the tobacco industry spends nearly \$25 million to advertise and promote cigarettes—this equates to more than \$1 million per hour, and is more than twice CDC’s recommended per capita annual investment in comprehensive tobacco control.⁹
 - Combined annual advertising and promotion for cigarettes and smokeless tobacco is \$9.17 billion annually.^{9,10}

Best Practices: Program Components

- *Best Practices–2014*’s guidance includes descriptions of the integrated, programmatic structure for comprehensive tobacco control programs that maximizes program effectiveness.⁵ This approach is key to the success of state tobacco control programs because the effectiveness of these programs is based on the synergy between their components. The whole is greater than the sum of the parts. No single component is a “magic bullet”, and individual interventions have less impact and less return on investment when they are implemented in isolation.⁵

- Based on the evidence of effectiveness documented in the scientific literature, as well as state experiences, CDC recommends that state tobacco control programs include all of the following components:
 - State and Community Interventions, including local and statewide policies and programs designed to influence societal organizations, systems, and networks that encourage tobacco-free social norms.
 - Mass-Reach Health Communication Interventions, including high-impact messages through paid and earned media to encourage smokers to quit, prevent youth and young adult tobacco use initiation, and to educate about the harms of secondhand smoke exposure.
 - Cessation Interventions, including promoting health systems change, expanding insurance coverage of proven cessation treatments, and supporting state quitline capacity.
 - Surveillance and Evaluation, including ongoing monitoring and evaluation of tobacco use, as well as tobacco-related attitudes, behaviors, and health outcomes, to better understand the problem and to achieve progress toward reducing tobacco use.
 - Infrastructure, Administration, and Management to enable adequate internal capacity within states, including a sufficient number of skilled staff to provide program oversight, technical assistance, and training.⁵
- In addition to these specific components, comprehensive tobacco control programs should integrate efforts to achieve equity by eliminating tobacco-related disparities across each of these components. *Best Practices–2014* outlines examples of ways programs can achieve this, such as featuring testimonials from a variety of people with different backgrounds in health education campaigns, as well as monitoring tobacco use across multiple subpopulations, particularly those with the greatest burden of use.⁵

Effectiveness of Comprehensive State Tobacco Control Programs

- Evaluations of comprehensive state tobacco control programs indicate that there is a dose-response relationship between investment in these programs and reductions in tobacco use. That is, the more states spend on these programs, the greater the reductions in smoking—and the longer states invest, the greater and faster the impact.⁵
- If each state implemented and sustained the recommended level of funding outlined in *Best Practices–2014*, millions fewer people would smoke and hundreds of thousands of premature tobacco-related deaths would be prevented in the United States.⁵ Longer-term investments would yield even greater effects.⁵ The resulting reductions in disease and death would translate into major savings in health care and productivity costs.
- Data from California—home to the first and longest-running state tobacco control program in the United States—provide the best example of the impact that such a program can have if sustained over time.
 - In January 1989, the California cigarette excise tax increased from \$0.10 to \$0.35 per pack, with about 20 percent of the resulting revenue being used to fund tobacco control efforts.
 - Following the implementation of a comprehensive, evidence-based program, the cigarette smoking rate among California adults fell from just under 23 percent in 1988 to just over 13 percent in 2006.¹¹

- As a result, compared with the rest of the country, heart disease deaths and lung cancer incidence in California have fallen at an accelerated rate. In fact, since 1998, lung cancer incidence has been falling four times faster in California than in the rest of the country.¹²
- For every dollar spent on tobacco prevention, states can reduce tobacco-related health care expenditures and hospitalizations by up to \$55.¹³
 - The amount is dependent on program effectiveness and longevity of investment—that is, the longer and more states invest, the larger the impact on youth and adult smoking.⁵
 - Over a 17-year period, California invested approximately \$2.4 billion in tobacco control and saw a \$55:\$1 return on the investment, as tobacco-related health care costs in the state were reduced by \$134 billion.¹³
- Florida provides another example of the impact of state tobacco control programs. Between 1998 and 2003, a comprehensive tobacco control program in Florida that included an aggressive youth-oriented media campaign reduced cigarette smoking rates by 50 percent among middle school students and by 35 percent among high school students.¹⁴
- Other states have also seen sharp percent reductions in youth smoking rates after implementing sustained comprehensive statewide programs.
 - For example, between 2001 and 2010, New York state’s tobacco control program reported that declines in adult and youth cigarette smoking prevalence outpaced national declines.¹⁵
 - This resulted in smoking-attributable personal health care expenditures in 2010 that were \$4.1 billion less than they would have been if the smoking prevalence remained at 2001 levels.¹⁵

Impact of Funding Cuts

- After the 1999 *Best Practices* report was published, overall funding for state tobacco control programs more than doubled.¹⁶ However, in the face of budget deficits and competing priorities, states have sharply reduced their investment in tobacco prevention and control in recent years, resulting in the near-elimination of tobacco control programs in some states.¹⁷
- In fiscal year 2014, only two states (North Dakota and Alaska) funded their tobacco control programs at CDC-recommended levels, and only five other states (Delaware, Wyoming, Hawaii, Oklahoma, and Maine) provided even half of the CDC’s recommended funding level outlined in *Best Practices-2014*.¹⁸
- Between 2008 and 2012, states cut tobacco prevention funding by 36 percent, or \$260.5 million.¹⁷ Unfortunately, this eroding trend has continued in recent years—the \$481.2 million states have allocated to tobacco control in fiscal year 2014 is one-third lower than state funding five years ago.^{17,18}
- The experiences of a number of states show that cutting funding for state tobacco control programs leads to rapid reversals of previous progress in reducing tobacco use.
 - For example, after funding for the Massachusetts tobacco control program was cut by 95 percent in fiscal year 2004, cigarette sales to minors increased, declines in youth smoking stalled, and the state’s per capita cigarette consumption rose.^{19,20} Between 2005 and 2006, after this funding cut, Massachusetts’s per capita cigarette consumption increased by 3.2 percent, while the national per capita consumption declined by 3.5 percent.¹⁹

- Similarly, after funding for Florida’s highly successful youth-oriented “truth” campaign was cut in 2004, youth cigarette smoking rates—which had been falling sharply—stabilized, and then began slowly increasing.²¹

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