TOBACCO CONTROL NETWORK

2012 POLICY PLATFORM

ON TOBACCO PREVENTION AND CONTROL

The Problem

Tobacco use is the single most preventable cause of death and disease in the United States (U.S.).[1] An estimated 45.3 million Americans (19.3% of all adults) currently smoke cigarettes.[2] **Cigarette smoking causes about 1 of every 5 deaths in the U.S. each year,** which is approximately 443,000 deaths (including 50,000 deaths from secondhand smoke).[1,3] On average, adults who smoke cigarettes die 14 years earlier than nonsmokers.[4] For every person who dies from tobacco use, another 20 suffer with at least one serious tobacco-related illness.[5] Cigarettes are not the only hazardous tobacco product; smokeless tobacco is also a significant health risk and is not a safe substitute for smoking cigarettes.[6]

While significant progress has been made in addressing tobacco use in the U.S. since the release of the first Surgeon General's Report on Smoking and Health in 1964[7], large disparities in smoking prevalence and tobacco-related diseases exist among groups differentiated by race/ethnicity, socioeconomic status, educational attainment, mental health, sexual orientation, occupation, and geography.[8,9, 10,11 12,13] Critical to reducing these disparities and achieving health equity is the identification and implementation of policies and program strategies that will accelerate the rate of change among these groups at the population-level.[14] Policies and program strategies that motivate and support successful quitting; that engage communities in change; and that provide the financial, human, and training resources necessary to denormalize tobacco use are essential to addressing tobacco-related disparities.

Reducing the prevalence of tobacco use among adults alone will not solve the public health problem. The 2012 U.S. Surgeon General's Report on youth and adult tobacco use states, "preventing smoking and smokeless tobacco use among young people is critical to ending the epidemic of tobacco use."[15] More than 80% of adult smokers begin by 18 years of age and 99% by age 26.[16]

The 2006 Surgeon General's Report on the *Health Consequences of Involuntary Exposure to Secondhand Smoke* concluded that there is no risk free level of exposure to secondhand smoke. [17] According to the 2006 report, secondhand smoke is proven to cause lung cancer, heart disease, serious respiratory illnesses such as bronchitis and asthma, low birth weight and sudden infant death syndrome.

Finally, tobacco use also exacts a huge economic toll. During 2000-2004, cigarette smoking was estimated to be responsible for $193 billion in annual health-related economic losses in the U.S. with $96 billion in direct medical costs and approximately $97 billion in lost productivity.[18]

The uptake and maintenance of tobacco use does not occur in a vacuum. Tobacco marketing exerts a powerful influence on tobacco use and undermines the effectiveness of comprehensive tobacco control programs.[19,20] In 2007 and 2008 cigarette companies spent $10.5 billion annually on advertising and promotional expenses in the U.S., nearly $29 million each and every day of the year.[21] Many subpopulations, including young people, are particularly vulnerable to tobacco promotions and advertising.

We Know What Works

The Tobacco Control Network (TCN) understands how to end the epidemic of tobacco use and the resulting enormous toll it takes on individuals, families and communities. We need coordinated application of the most effective strategies – combining regulatory, economic, clinical and social approaches – that work together to stimulate public support and change social norms around tobacco use. Increasing the price of tobacco products, implementing smoke-free policies, and comprehensive tobacco control programs that include support for cessation services and media campaigns, are the policy interventions that most effectively reinforce smoke-free norms and drive down tobacco use, as follows:

Raise the Price

In each state, increase the excise tax on cigarettes to at least $1.50 per pack of cigarettes with an equivalent tax increase on the prices of Other Tobacco Products (e.g., smokeless, cigars, pipe, dissolvables), and specifically designate a significant portion of the revenue for comprehensive tobacco control programs to achieve greater equity in programs that reach lower socio-economic communities.

"*The single most direct and reliable method for reducing consumption is to increase the price of tobacco products, thus encouraging the cessation and reducing the level of initiation of tobacco use.*"

-*Taking Action to Reduce Tobacco Use*
National Academy of Sciences Institute of Medicine
1998

This statement has been echoed by every major scientific body in the U.S. as well as globally, including the U.S. Surgeon General, National Cancer Institute, U.S. Centers for Disease Control & Prevention, U.S. Task Force on Community Preventive Services, President's Cancer Panel, World Bank, and the World Health Organization. Studies show that for every 10% increase in the cost of cigarettes, consumption declines by 4%.[22] Among youth and pregnant women, the resulting decline in consumption is 6.5%.

Increased excise taxes reduce tobacco use in three ways:

- Decrease consumption among smokers. Smokers who continue to use cigarettes cut down the number of cigarettes consumed
- Increase cessation. The number of smokers who successfully quit increases, raising the number of ex-smokers
- Reduce initiation. The number of young people who never become addicted to tobacco increases.

As of July, 2012, the average excise tax in the U.S. is $1.49/pack, not including local excise taxes that make the average even higher.[23]

Smoke-free Air Laws

Enact uniform local, state, and tribal 100% smoke-free air laws in order to protect all workers and the public from exposure to tobacco smoke. These laws should cover all workplaces and public places, including restaurants, bars, and gaming areas in accordance with the Fundamentals for Smoke-free Workplaces Guide. Additionally, the definition of "smoking" in these laws should be broadened to include electronic nicotine delivery systems where it is feasible and appropriate to do so.

The 2006 Surgeon General's Report, ***The Health Consequences of Involuntary Exposure to Tobacco Smoke,*** and the 2010 Surgeon General's Report, ***How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Diseases*** confirm the known health effects of secondhand smoke exposure, including immediate adverse effects on the cardiovascular system, and coronary heart disease and lung cancer. An estimated 50,000 non-smokers die every year as the result of breathing other people's tobacco smoke. The 2006 report concluded that there is no safe level of exposure to secondhand smoke and that establishing smoke-free environments is the only proven way to prevent exposure.

A systematic review of U.S. smokefree policies in workplaces, pubs, and restaurants concluded that smoke-free policies protect nonsmokers from the death and disease caused by exposure to secondhand smoke and found that there was a reduction in hospital admissions for acute coronary syndrome after the passage of smoking bans.[24] Furthermore, smoke-free policies improve the health of smokers by reducing cigarette consumption and increasing quit attempts. As a result of the overwhelming evidence from peer-reviewed, scientific studies demonstrating that there is no safe level of secondhand smoke exposure, the Centers for Disease Control and Prevention issued a

warning for anyone at risk for heart disease to avoid smoke-filled indoor environments completely.[25]

As of April 2012, 29 states, Washington, D.C., Puerto Rico, and the U.S. Virgin Islands plus hundreds of cities and counties, have enacted strong smoke-free laws that include restaurants and bars. Despite this progress, more than 36% of the nation's population is, as yet, not covered by comprehensive smoke-free air policies.

Tobacco control work operates in a dynamic environment and practitioners must demonstrate agility in responding to the evolving landscape if tobacco-related public health gains are to be maintained. One rapidly growing area of concern is the manufacturing, distribution, marketing and use of electronic cigarettes (e-cigarettes).

In its January 2010 decision, *Sottera, Inc. v. Food & Drug Administration, 627F.3d891 (D.C. Cir.2010)* the U.S. Court of Appeals for the D.C. Circuit determined that the U.S. Food & Drug Administration may not regulate electronic cigarettes (e-cigarettes) as drug or medical devices. The Court held that e-cigarettes and other products made or derived from tobacco can be regulated as tobacco products under the Family Smoking Prevention and Tobacco Control Act of 2009 unless they are marketed for therapeutic purposes. In April 2011, the Food & Drug Administration issued a letter to stakeholders announcing that it intended to comply with the decision.[26]

As a result, when possible, the TCN encourages state, local and tribal governments to include electronic nicotine delivery systems such as e-cigarettes and e-hookah in the definition of "smoking" within smoke-free air and other tobacco control laws where it is feasible and appropriate to do so. Testing of e-cigarettes by the Food & Drug Administration and others has found they contain carcinogens and other toxic substances.[27] Furthermore, these products are simultaneously being marketed as cessation aids as well as in candy and fruit flavors that are appealing to youth. Additionally, the use of e-cigarettes in environments where smoking is not allowed (e.g., airplanes, indoor worksites, restaurants and bars) erodes no-smoking social norms, is confusing to the public, and increases the complexity and cost of enforcing non-smoking laws. Given the lack of credible data regarding the safety of e-cigarettes and the potential for the widespread use of these products to undermine the public health gains resulting from smoke-free air laws, it is in the best interest of the public's health to address e-cigarettes as part of comprehensive laws designed to protect the public's health from secondhand smoke exposure.

Funding for Sustainable, Comprehensive Programs

Fully fund state tobacco control programs in accordance with the 2007 Centers for Disease Control and Prevention's (CDC) Best Practices for Comprehensive Tobacco Control. One way this could be accomplished is by dedicating a small portion of what states collect in tobacco tax revenue and tobacco industry settlement payments to tobacco control activities.

In fiscal year 2012 state governments will collect $25.6 billion in revenue from the tobacco settlement and tobacco taxes, but will spend only 1.8% of it — $456.7 million — on programs to

prevent kids from smoking and help smokers quit. This means the states are spending less than two cents of every dollar in tobacco revenue to fight tobacco use. With nearly 20% of Americans still smoking, the report, *A Broken Promise to Our Children*[28] warns that continued progress against tobacco use – the nation's number one cause of preventable death – is at risk unless states increase funding for tobacco prevention and cessation programs.

Tobacco prevention and cessation programs work to reduce smoking, save lives and save money. Maine, which ranked first in funding tobacco prevention programs from 2002 to 2007, reduced smoking among high school students by 54% between 1997 and 2009.[29] Washington State, before virtually eliminating its program in 2011, reduced adult smoking by one-third and youth smoking by more than one-half[30]. An August 2008 study found that California's tobacco control program, the nation's longest-running, saved $86 billion in health care costs in its first 15 years, compared to $1.8 billion spent on the program, for a return on investment of nearly 50:1.[31] Conversely, if funding is cut, progress can be stalled or even reversed as in states such as Massachusetts, Florida, Indiana and Minnesota.

Every scientific authority that has studied the issue, including the Institute of Medicine, the President's Cancer Panel, the National Cancer Institute, the CDC, and the U.S. Surgeon General, has concluded that when properly funded, implemented and sustained, comprehensive tobacco control programs reduce smoking among both youth and adults.

Other Promising Practices

These proven policies are enhanced by a comprehensive approach that includes other promising practices. States that have already achieved success in the three top priorities are encouraged to engage in other population-based approaches to change social norms, including:

Other Secondhand Smoke Considerations

Workplace smoke-free air laws protect non-smokers from exposure to secondhand smoke and they support cessation by decreasing consumption of cigarettes and prompting quit attempts. As such, smoke-free air laws protect non-smokers and support cessation by motivating quitting and facilitating sustained abstinence.

Because these laws are very effective at both the prevention and cessation level, states, local governments and tribes are encouraged to expand the use of secondhand smoke protection policies to other settings and to incorporate the use of other tobacco products where appropriate. These settings include smoke-free multi-unit housing; health care campuses, universities, colleges, and trade schools, and other worksite campuses; public and recreational outdoor spaces; and tobacco-free schools, childcare, and foster care. Governmental agencies and communities are also encouraged to explore incorporating smoke-free and tobacco-free requirements into General Plans, building codes and zoning requirements in order to facilitate the adoption of a wide variety of secondhand smoke protections.

Of these "Other Secondhand Smoke Consideration" areas, smoke-free multi-unit housing and outdoor areas are important areas for work. Smoke-free multi-unit housing interventions impact a large number of vulnerable populations and protect non-smokers in their home. Smoke-free outdoor air policies are a valuable denormalization strategy and have been effective in bringing in new partners concerned about the health of children and the environmental impact caused by toxic cigarette butt waste.

- **Smoke-free Multi-Unit Housing.** Approximately 40 million Americans live in multi-unit housing properties, which account for 31.5% of all housing units in the United States. The home is a major source of secondhand smoke exposure for both adults and children.[32] While the proportion of households with voluntary no-smoking rules has increased since the early 1990s, nonsmoking residents in multi-unit housing are not adequately protected from the infiltration of secondhand smoke into their units. For example, a recent study of low-income Boston apartments found detectable air nicotine levels in 89 percent of the units occupied by nonsmokers.[33] In some studies, nearly 50% of multi-unit housing residents report secondhand smoke infiltration from other units.[34]
- **Smoke-free Outdoor Air.** In response to increased public demand and new scientific information on the health hazards in close-quarter outdoor areas, many communities with smoke-free indoor air laws have expanded, or are considering expanding, smoke-free protections to some outdoor public places. These areas include outdoor workplaces, sports arenas and fields, restaurant and bar patios, service lines, transit waiting areas, public events like county fairs and farmer's markets, as well as parks, beaches, and recreation areas.

Point of Sale Restrictions

Point of sale restrictions represent an area of promising tobacco control practice as a result of the authority extended to states, communities, and tribes resulting from the enactment of the 2009 Family Smoking Prevention and Tobacco Control Act and a growing body of scientific literature linking the point-of-sale environment to the uptake and maintenance of tobacco use. These policy strategies are recommended as an enhancement to core tobacco control strategies focused on increasing the price of tobacco products, extending smoke-free restrictions, and ensuring adequate funding for comprehensive tobacco control programs. State, local and tribal governments are strongly encouraged to work with the Tobacco Control Legal Consortium or similar agencies when developing and writing policies to avoid legal challenges. Because the retail environment is a rapidly evolving area of tobacco control policy efforts, an emphasis on local policy efforts, where not pre-empted, may be an especially appropriate level to begin addressing point-of-sale restrictions. State policy initiatives should proactively seek to avoid local preemption.

Retail environments are an important environment for tobacco companies to promote their products, segment the market and target tobacco users who are contemplating quitting or who have recently quit. In fact tobacco companies spend more than 85% of their advertising and promotional dollars at the point-of-sale.[35] These marketing dollars are used for point-of-sale advertising, payments to retailers to obtain prime locations for their products and advertising, and a variety of price discounting tools.

In-store tobacco marketing is very effective. Tobacco product displays increase the likelihood of youth smoking initiation. Adolescents who visited tobacco retail stores with the most cigarette advertising and product displays at least two times a week were more than twice as likely to initiate smoking. Even adolescents who visited these stores less than twice a week were significantly more likely to initiate smoking.[36] Among adults, the evidence suggests that as tobacco marketing increases, tobacco consumption increases. Point-of-sale tobacco promotions, particularly price promotions, influence impulse tobacco purchases and undermine quitting by increasing the affordability of tobacco products. Twenty-five percent of smokers report impulse buying and one-third of recent ex-smokers report urges to start smoking after seeing tobacco displays.[37] [38]

Urban, ethnic minority, and low socio-economic status communities are often disproportionately exposed to tobacco products and advertising in retail settings. Storefront tobacco advertising is more prevalent in predominately low-income, racial and ethnic minority communities and mentholated cigarette brands are marketed more frequently in these communities.[39] In Minneapolis neighborhoods with large minority populations, researchers found that the price of menthol, a brand popular with African Americans, was lower than in non-minority areas.[40] An Iowa study found a higher density of tobacco retail stores in areas with lower median household income, areas with a higher percent of African American residents, and areas with a higher percent of Latinos residents.[41]

Several studies have also found a significant relationship between tobacco retailer density and smoking rates among high school students in urban areas.[42,43] One study found that smoking prevalence was higher at schools in neighborhoods with five or more tobacco outlets than at schools in neighborhoods without any tobacco outlets[44]. Another study found that the higher the density of stores that sell tobacco near high schools in urban areas, the more likely the students were experimental smokers.[45] Youth who live where cigarette prices are lower and where there are more tobacco advertisements and promotions are also more likely to smoke.[46]

- **Tobacco Retail Licensing.** Tobacco retail licensing with fees specifically earmarked for enforcement provides a flexible policy strategy that may be used to address a broad spectrum of issues including: tax evasion, tobacco sales to minors, location of tobacco sales, types of business that may sell tobacco products, and the type or package size of tobacco products offered for sale (e.g., flavored products, pack/volume size of products). Tobacco retail licensing also provides tools to tie in with other community health issues related to alcohol sales, drug use, safety, and nutrition. For example, violations for alcohol, drug paraphernalia or nuisance (loitering) laws or Women, Infants and Children (WIC) vendor fraud could result in suspension or revocation of the tobacco retailer license.
- **Tobacco Retailer Density/Zoning**. Density addresses strategic use of retailer licensing programs and zoning regulations by state and local municipalities to control the number, type, location and density of tobacco retailers. These types of requirements may be

enacted as individual laws or incorporated in tobacco retail licensing laws or into General Plans.

- **Tobacco Product Displays**. Tobacco product display policy strategies address access to tobacco products and their display in view of customers. Policy strategies include eliminating the self-service display of products or requiring that tobacco products to be kept totally out-of-sight of all customers, minors and adults alike. Laws prohibiting the self-service display of tobacco products have been widely adopted throughout the U.S. While laws requiring that tobacco products be kept out-of-view have been adopted in a number of countries including, Australia, Canada, Iceland, Ireland, Thailand, Norway, New Zealand, and the United Kingdom, this is a new policy strategy in the U.S. [47,48,49] In April 2012, the Village of Haverstraw, Rockland County, New York became the first jurisdiction in the U.S.to adopt a law requiring tobacco products to be kept out of the view of customers. The New York Association of Convenience Stores and seven tobacco companies subsequently filed a lawsuit challenging the Haverstraw law.[50]
- **Content Neutral Advertising Restrictions.** This type of policy is considered content neutral affecting all types of advertising, including tobacco advertisements, and is considered to be the least controversial approach to restricting time, place or manner of tobacco advertising. These types of laws are frequently enacted for community beautification or safety reasons. For example, laws that limit the total amount of advertising on store windows have been found to reduce the amount of tobacco advertising.[51]
- **Non-tax approaches to increasing the price of tobacco**. These include: (1) a strong Cigarette Minimum Price Law which sets a floor price for cigarettes and other products and prohibits the sale of these products for less than the minimum price; (2) restrict/eliminate tobacco industry coupons, coupon redemption, discounts, multi-pack discount offers, and gift with tobacco purchase; (3) tobacco mitigation fees to ameliorate the environmental impact and blight caused by tobacco-related litter; and (4) adding a Disclosure or Sunshine Law requiring tobacco companies to disclose payments and discounts paid to retailers within a specific geographic area such as a city, county or state.

Motivate and Help Tobacco Users to Quit

The rate at which a population of tobacco users successfully quits is a function of the rate at which they try to quit (quantity) multiplied by the rate of efficacy for those quit attempts. The efficacy of quitting is a function of the quality, availability and utilization of effective cessation treatment. In theory, increasing either the number of quit attempts or the quality of the quit attempts would increase the rate of quitting behavior in a given population. Interventions that enhance the quality of a quit attempt include the use of tobacco cessation counseling and medication. These treatments are effective when used by themselves and in combination they are even more effective than when either is used alone.[52] However, the majority of smokers quit without using such treatments.[53]

Given that most smokers quit without using an evidenced based treatment and present fiscal and system challenges to providing easy access to evidenced-based cessation treatments to all, the overarching goal of any cessation strategy should be to increase the number of quit attempts among tobacco users and to quickly cycle those who relapse back into making a quit attempt while simultaneously seeking to improve the efficacy of quit attempts. Many of the interventions that motivate quit attempts have been previously discussed. These include: 1) increasing the price of tobacco products, 2) restricting when and where tobacco products may be used, and 3) mass media campaigns. Other interventions that motivate and help tobacco user to quit are: 1) health care provider advice to quit, 2) increasing the accessibility of cessation aids, and 3) helping tobacco users to feel more hopeful about quitting by re-framing a relapse as practice for quitting rather than as a failed attempt.[54] Below are recommendations for promoting a dual cessation strategy that simultaneously seeks to increase in the number of quit attempts while improving the efficacy of quit attempts.

Reduce Barriers to Cessation Assistance

State tobacco control programs are well poised to facilitate the adoption of renewable and sustainable approaches to cessation within health insurance plans and health care systems as a result of their considerable knowledge and skills about tobacco cessation treatment and the use of media outreach campaigns. State tobacco control programs can leverage their expertise in these areas in working with health insurance plans and health care systems. Additionally, through the TCN, state tobacco control program have access to a considerable network of people who are willing to share their experiences, lessons learned, and resources to support the adoption and implementation of population-based cessation system change.

- **Partner with state Medicaid programs to provide and promote utilization of comprehensive coverage of tobacco dependence treatments consistent with the U.S. Public Health Services Clinical Practice Guidelines, Treating Tobacco Use Dependence (2008 Update) and minimize barriers to treatment access.** Medicaid beneficiaries use tobacco at higher rates than the general population, are less able to pay for tobacco cessation treatments, and less able to afford the cost of illness and death from tobacco use.
- **Encourage state employee health plans to provide and promote utilization of comprehensive coverage of tobacco dependence treatments consistent with the U.S. Public.** State governments are often among the largest employers in states and all provide health insurance to their employees. These health plans can lead by example and cover cessation treatment for tobacco users to not only create a healthier state workforce, but also to serve as a model for other providers in the state.
- **Support System Change within the Health Care and Behavioral Treatment Systems**. Encourage and support health care systems and behavioral treatment systems to systematically implement tobacco user identification systems; evidence-based tobacco cessation treatment consistent with the U.S. Public health Services Clinical Practice Guidelines Treating Tobacco Use and Dependence; and provide education, resources and

feedback to providers to support and facilitate their cessation efforts. Such efforts may include facilitating the implementation of electronic medical record (EMR) systems for tobacco use exposure assessments, treatment and referral consistent with federal "Meaningful Use" guidelines (i.e., EMR use achieves significant improvements in care.).

- **Support Implementation of the 2012 Joint Commission Tobacco Treatment Measures**. Encourage and support hospitals to implement the 2012 Joint Commission Tobacco Treatment Measures, including screening inpatients for tobacco use, providing cessation treatment during the hospitalization stay and at discharge, and assessing tobacco use status post discharge.
- **Encourage Quitline Use.** Helping tobacco users quit by phone is an essential part of any state's cessation efforts. The cost of quitlines can now be covered for Medicaid participants. Funding for quitlines, whether through Medicaid (which is matched dollar-for-dollar by the federal government) or through a well-funded comprehensive state tobacco control program allows equal access to timely cessation help.

The Tobacco Control Network (TCN) is comprised of tobacco control program managers and additional staff from each state, territory, and D.C., allowing the network to harness a wealth of expertise from across the country. The TCN acts as a catalyst to strengthen the tobacco control movement by facilitating knowledge exchange among its members, fostering leadership development through member support services, and collaborating with partners at all levels of tobacco control.

This document is intended to represent the widely held consensus on policy priorities among state tobacco control programs. To learn more, visit our website at www.ttac.org/TCN or email tcn@sph.emory.edu.

Suggested Reading

We know what works:

www.thecommunityguide.org/tobacco

Smoke-free Air Laws:

www.surgeongeneral.gov/library/secondhandsmoke/
http://no-smoke.org/pdf/CIA_Fundamentals.pdf

Raise Cost of Tobacco Products:

www.tobaccofreekids.org/reports/state_tax_report/downloads/Tax%20Report%20ES%20&%20Narrative%202-09-10.pdf

http://publichealthlawcenter.org/sites/default/files/resources/tclc-guide-state-taxation-
http://publichealthlawcenter.org/sites/default/files/resources/tclc-guide-state-tax-OTP-2012.pdfcigs-2012.pdf

Funding and Sustainability:

For Current State Funding levels, go to:
www.tobaccofreekids.org/research/factsheets/pdf/0219.pdf

To see the CDC Best Practices for each state, go to:
www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2007/BestPractices_SectionC_BudgetsByState.pdf

To view the full 2007 CDC Best Practices report, go to:
www.cdc.gov/tobacco/stateandcommunity/best_practices/

Reference: Campaign for Tobacco-Free Kids fact sheet on "The Impact of Funding Reductions to State Tobacco Control Programs"
www.tobaccofreekids.org/research/factsheets/pdf/0270.pdf

For local state and national organizations working to counteract tobacco product sales and marketing at the point of sale: www.CounterTobacco.org

Healthy Homes Manual: www.cdc.gov/healthy**homes**/Healthy_**Homes**_Manual_WEB.pdf

Role of Media in Promoting and Reducing Tobacco Use:

http://cancercontrol.cancer.gov/tcrb/monographs/19/index.html

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