TOBACCO CONTROL AND PREVENTION

American College of Physicians

A Policy Monograph

2010

Tobacco Control and Prevention

Summary of Policy Monograph Approved by the ACP Board of Regents, April 2010

What Does Tobacco Control and Prevention Involve?

Tobacco use is the leading cause of preventable death and disease in the United States. While significant progress has been made over the last 50 years to reduce tobacco use, it remains a daunting problem. Twenty-one percent of adults currently smoke cigarettes, and 20% of high school students report having smoked cigarettes in the past 30 days. Therefore, it remains important that stakeholders aggressively work to reduce tobacco use rates. Doing so will ensure that a new generation does not succumb to a lifetime of harmful addiction, disease, and untimely death.

The tobacco problem cannot be curbed by piecemeal action. Effective tobacco control occurs when a concerted effort is made to establish and financially maintain comprehensive tobacco control initiatives by increasing tobacco excise taxes, prohibiting smoking in public places, preventing tobacco use among young people, facilitating smoking cessation programs, and banning tobacco additives such as menthol flavoring. In 2009, the FDA was given the authority to regulate tobacco products. This important step signals promise that tobacco use can be greatly reduced, but regulation alone is not sufficient.

Why is Controlling and Preventing the Use of Tobacco Important?

Though anti-tobacco use efforts have been remarkably successful, tobacco use remains high. Each year, cigarette smoking is the cause of over 440,000 deaths, nearly 50,000 of which are attributed to exposure to secondhand smoke. The 2004 Surgeon General's report concluded that smoking affects nearly every organ in the human body. Tobacco and its smoke contain over 4,000 chemicals, including 60 known carcinogens.

Further, tobacco users are not 002 Tw whic[Tw onll ind0.78 0baccdu0 Td(attr5 Td [been made 11ablis)e6

including counseling and medication – to all qualifying individuals. Physicians should help their patients quit.

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3. **All states should commit to funding tobacco control efforts at CDC-recommended levels. All states should establish requirements that an appropriate portion of tobacco-generated revenue be directed toward tobacco control efforts. Local governments should be permitted to implement tobacco excise taxes beyond state levels.**

4. **Youth tobacco education and prevention efforts, such as antismoking media campaigns and school-based interventions, must be enhanced and properly funded. Information and interventions related to cigars, pipes, smokeless tobaccos, and other cigarette alternatives should be incorporated into youth antismoking efforts.**

5. **The FDA should implement a ban on menthol flavoring in all tobacco products, as it has done with other flavors in cigarettes.**

6. **State and local governments should take necessary action to establish comprehensive smoke-free laws banning smoking in all nonresidential indoor areas, including workplaces, restaurants, and bars. State and local governments should work to control smoking in residential areas, such as apartment and condominium buildings.**

7. **Comprehensive tobacco control efforts should seek to reduce use of cigars and pipes in addition to cigarettes, particularly among young people and cigarette smokers.**

8. **The FDA should be authorized to regulate electronic cigarettes until convincing evidence develops that they are not addictive.**

9. **Smoking and tobacco use in movies and television should be discouraged, and the media industry should take responsibility to emphasize the dangers of tobacco use, particularly to young people.**

Background

Tobacco use is the leading cause of preventable death and disease in the United States[4]. Each year, cigarette smoking is the cause of over 440,000 deaths, nearly 50,000 of which are attributed to exposure to secondhand smoke[5]. The World Health Organization estimates that one billion people worldwide could die from tobacco-related illness by the end of the 21st century if current rates of tobacco use continue unabated[6]. Each day, nearly 4,000 young people aged 12 to 17 smoke their first cigarette, 25% of whom will become regular smokers[7]. According to the Institute of Medicine (IOM), smoking-related deaths •account for more deaths than AIDS, alcohol, cocaine, heroin, homicide, suicide, motor vehicle crashes, and fires combined[8]. Tobacco use peaked in the mid-1960s when over half of adult men and about 35% of adult women smoked[9]. Over the past 40 years tobacco consumption rates have declined significantly, a trend described as 1 of the 10 greatest public health achievements of the 20th century[10].

between the lip and gum), are related to adverse health effects.[25-28] Like cigarettes, smokeless tobacco products contain nicotine and are addictive. Additionally, smokeless tobacco products contain a range of carcinogens and have been linked to oral and other cancers as well as precancerous oral lesions.[26,27,28] A 1986 report by the U.S. Surgeon General concluded that smokeless tobacco products pose a significant health risk and that they are not safe alternatives to cigarettes.[29,30]

Cigars and pipes also pose a health risk, particularly if the smoke is inhaled.[31] Even if the smoker does not inhale, nicotine, carcinogens, and other toxins can be absorbed through the mouth and other parts of the body. Since cigars often contain more tobacco than cigarettes, the smoke of larger cigars may contain the same amount of nicotine as a pack or more of cigarettes.[31] Evidence also suggests that cigar and pipe smoking reduce the user•s lung function and increases airflow obstruction compared with those who have never smoked. Long-term pipe and/or cigar use may increase risk for chronic obstructive pulmonary disease.[32] Further, cigar smoke may be more toxic than cigarette smoke.[33]

sympathetic legislators and political organizations; establishment of front groups, such as the Michigan Citizens for Fair Taxes and the National Smokers Alliance; charitable giving to a variety of organizations; and buying the expertise of outside economists, medical researchers, and others.[61]

As evidence emerged in the 1970s about the harmful effects of secondhand smoke, state and local governments began placing restrictions on smoking in public places. Starting with a 1973 Arizona law limiting smoking in some public places, efforts by regulators, businesses, and legislators at various levels sought to control secondhand smoke exposure, chiefly by separating smokers from nonsmokers or prohibiting smoking altogether.[62] Indoor-air laws addressing smoking in enclosed spaces were facilitated by a growing movement of nonsmoker advocates motivated by growing evidence of the harmful effects of secondhand smoke. A rising grassroots effort by antismoking advocates led to the Great American Smokeout and more aggressive efforts by established health advocates, such as the American Lung Association, to educate the public about the harmful effects of smoking to smokers and nonsmokers alike.[63,64] The 1980s saw a number of other landmark changes. In 1982, the federal excise tax on cigarettes was doubled, and in 1986, Surgeon General C. Everett Koop released a report concluding that secondhand smoke posed a serious public health threat, further buttressing the antismoking movement's arguments.[65] By 1983, yearly per capita consumption of cigarettes had declined 20% from the 1963 level.[66]

In 1992, Congress enacted the Synar amendment that sought to reduce the sale of tobacco to young people. In 1996, the FDA began regulating the sale of tobacco products to young people and established monetary fines on merchants who sold tobacco products to minors; however, the U.S. Supreme Court later ruled that the agency did not have such authority and the program was eliminated.[67] A major victory for antismoking interests occurred in 1998, when 46

2. Public and private insurers, as well as state, community, and employer-based entities, should provide all effective comprehensive tobacco cessation and treatment benefits – including counseling and medication – to all qualifying individuals. Physicians should help their patients quit.

Nicotine is highly addictive. If cigarettes were introduced into the marketplace today, according to the IOM they would qualify as a Schedule 1 drug under the Controlled Substances Act, alongside illicit drugs like heroin and LSD, because of their potential for abuse and lack of medical benefit.[84] Despite the addictive nature of nicotine, a 2008 CDC survey reported that of the 94 million people who had smoked at least 100 cigarettes in their lifetime, 51% had quit at the time of the interview.[85]

Smoking cessation programs are essential to reducing smoking-related preventable death. While an in-depth review of smoking cessation methods are outside the scope of this paper, typical effective treatments include a combination of counseling and FDA-approved medications, such as nicotine replacement gums, nasal sprays, and patches, as well as prescriptions that assist in cessation.[86,87] Without the help of smoking cessation programs, quit rates are very low … only about 4% to7% of smokers are able to quit without medication or other assistance; when smoking cessation medications are used, 25% to 33% of smokers are able to quit for at least 6 months.[88] According to the Surgeon General•s 1988 report on nicotine addiction, •Tobacco use is a disorder which can be remedied through medical attention; therefore, it should be approached by physicians and other health care professionals just as other substance-use disorders are approached: with knowledge, understanding, and persistence.Ž[89]

Physicians and other health care professionals play a crucial role in helping smokers quit, but not all smokers receive such guidance from their doctors. In the mid-1990s, about 48% of smokers were told to quit smoking by their physician or health provider; by the mid-2000s, reported advice rates increased to 61%.[90] However, only about 28% of smokers received smoking cessation assistance in the form of medications or other methods from their health care provider. If 90% of smokers received advice and assistance to quit smoking, 42,000 lives could be saved each year.[91] In 2000, the federal government recommended that physicians and other health care professionals use •the five A•sŽ when treating nicotine-addicted patients, recommending that physicians *ask* patients of their smoking habits, *advise* them to quit, *assess* patient•s willingness to quit, assist the patient in their attempts to quit, and *arrange* for follow-up contact.[92]

States and community efforts play an important role in tobacco control programs. Maine•s Tobacco Treatment Initiative supports smokers trying to quit by providing telephone counseling services (•HelplineŽ), vouchers for nicotine replacement products, and training for health professions in effective tobacco cessation treatments. The Helpline services have proved successful, as 21% of smokers who had received assistance from the Helpline remained tobacco-free for 6 months.[93] New York City successfully implemented a comprehensive tobacco control effort that included physician outreach and education, cessation clinics, and wide distribution of nicotine-replacement aides, leading to a marked decrease in smoking rates.[94] Preliminary evidence shows that Massachusetts• Tobacco Cessation and Prevention Program has dramatically lowered smoking rates among Medicaid beneficiaries by making antismoking medications available at very low cost.[95] Employers can also play a role in assisting employees• attempts to quit using tobacco. Smoking cessation programs improve employee

health and result in short-term costs savings for the employer due to reduced medical and life insurance costs.[96] Novartis Pharmaceuticals implemented a tobacco cessation program, partnering with a pharmacy benefit manager and a number of telephone-based counseling services to help employees quit using tobacco. The program helped initiate a change in corporate culture that promoted healthy living rather than reactive health care.[97]

Public and private insurance should also improve access to tobacco cessation treatments. Medicare currently covers smoking cessation, including counseling and medication therapy, but the benefit is limited only to beneficiaries with a condition or medication regimen adversely affected by smoking or tobacco use.[98] Smoking cessation is especially important for the Medicaid population, since the smoking rate among Medicaid beneficiaries and other low-income people is significantly higher than that of the general population.[99] Medicaid coverage of smoking cessation treatments varies throughout the nation. Eighty-four percent of Medicaid programs offer some form of smoking cessation coverage, but only six programs offer comprehensive treatment that includes all effective counseling and medication services.[100] Further, the level of coverage may depend on the type of Medicaid coverage (fee-for-service versus managed care) and may only be available to pregnant women.

Providing smoking cessation services is cost-effective. The Congacyensive 2but thece the smok

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profound among adolescents; for every 10% increase in the price of cigarettes, 7% fewer teenagers will smoke.[107] Excise taxes have been shown to reduce smoking rates, but they are most effective as part of a comprehensive effort to eliminate tobacco use.[108] In the early 1990s, Massachusetts raised the state excise

students surveyed had smoked a cigarette on at least 1 day in the 30 days prior to the survey.[122] The same survey found that 8% of high school students had used smokeless tobacco at least 1 day in the 30 days prior to the survey.[123] The earlier people start smoking, the more likely they will become heavy smokers and develop a long-term addiction to nicotine.[124] Among adolescents who currently smoke, about half have tried to quit.[125] Smoking can hinder physical development in adolescents. Active cigarette smoking during adolescence reduces lung growth and function and facilitates the development of risk factors related to heart disease.[126] Peer pressure, potential for stress relief, facilitation of social interaction, positive perceptions of smoking, and inability to appreciate the risks of tobacco use are among the factors that contribute to smoking initiation and regular use among adolescents.[127,128,129]

gram, a unique mix of youth-oriented media campaigns, school-based interventions, and wide distribution of antismoking information, has been shown to reduce smoking rates and perception of tobacco use among targeted youths.[140] As suggested by the CDC, youth prevention efforts must be comprehensive and encourage prevention and/or cessation, incorporate mass media education campaigns, school-based interventions, and community engagement.[141] Further, the IOM recommends that medical societies, including ACP, encourage members to urge parents to keep a smoke-free home, educate their children about the dangers of smoking, impart that their children should not smoke, and monitor their children's tobacco use.[142]

more likely than *People* magazine to contain advertisements for menthol cigarettes.[159] R.J. Reynolds even prepared to release an African-American…focused cigarette brand called Uptown, which contained nearly as much nicotine as unfiltered Camels, but withdrew the project after protests from public interest groups.[160,161]

While the link between menthol cigarettes and higher rates of tobacco-related disease may be unclear and warrants further research, evidence suggests that menthol cigarettes are more addictive and make it more difficult to quit than other varieties. Prior to passage of the FSPTCA, a bipartisan group of anti-smoking advocates, including seven former U.S. HHS/HEW Secretaries, sent a letter to congressional legislators stating that, •by failing to ban menthol, the bill caves to the financial interests of tobacco companies and discriminates against African Americans„the segment of our population at greatest risk for the killing and crippling smoking-related diseases*ƒ* (m)enthol should be banned so that it no longer serves as a product the tobacco companies can use to lure African American children.Ž[162] Given their appeal to minority groups and young smokers … probably the result of decades of aggressive marketing campaigns by the tobacco industry … ACP supports efforts to ban menthol in cigarettes and other tobacco products.

6. State and local governments should take necessary action to establish comprehensive smoke-free laws banning smoking in all non-residential indoor areas, including workplaces, restaurants, and bars. State and local governments should work to control smoking in residential areas, such as apartment and condominium buildings.

As the harm of secondhand smoke exposure has become more evident, a number of jurisdictions have established bans on smoking in workplaces, restau-

hand smoke and cardiovascular disease found that smoking bans lead to a decrease in heart attacks.[171] Smoke-free policies benefit smoking cessation efforts since smoking bans at home and the workplace may motivate more smokers to attempt to quit and stay smoke-free for at least 6 months.[172,173] Despite claims that smoking bans would be detrimental to restaurant and bar revenue, evidence shows that such laws have had neither positive nor negative effects.[173] Further, attempts to mitigate secondhand smoke exposure by installing ventilation systems have proven to be ineffective in eliminating secondhand smoke risk.[174]

ACP supports efforts to ban smoking in workplaces, restaurants, bars, and other public areas. Such smoke-free policies have been shown to greatly reduce harmful secondhand smoke exposure, exposure-related disease rates, reinforce smokers• attempts to quit, and solidify nonsmoking as a social norm.[175] However, efforts also must be made to encourage smoke-free policies in residential areas, such as multiunit apartment buildings. Residents of apartment buildings, for instance, are exposed to secondhand smoke in common areas and through ventilation systems. Children are most likely to be exposed to secondhand smoke in the home and one quarter of children aged 3-11 live with at least one smoker.[176] Smoke-free policies have been slow to reach residential areas, but some localities have enacted smoking restrictions on multiunit apartment buildings. In 2007, Temecula, California, adopted a law requiring landlords of larger apartment buildings to designate a percentage of units as smoke-free.[177] Additionally, at least 165 local public housing authorities have established restrictions on resident smoking.[178] Landlords and residential associations should be encouraged to designate smoke-free apartment units and common areas, and smoking-related rules should be included in leases and housing agreements.[179] Antismoking advocates have facilitated the process of matching smoke-free housing with potential tenants. In Maine, potential tenants can access a Web-based registry listing smoke-free dwellings.[180] Physicians should remind patients of the harm caused by secondhand smoke and maintain that patients should stop smoking at home and in other enclosed areas as part of their comprehensive smoking cessation effort.

7. Comprehensive tobacco control efforts should seek to reduce use of cigars and pipes in addition to cigarettes, particularly among young people and cigarette smokers.

The College supports the Surgeon General•s emphatic message that there is no safe tobacco product and advocates for initiatives to reduce the use of cigarettes, smokeless tobacco, cigars, and other tobacco products. Comprehensive tobacco control efforts should devote attention to reducing use of cigarettes, cigars, pipes, and smokeless tobacco products given their deleterious effects on health. This is of particular concern because some cigarette users, faced with increasing cigarette costs and health concerns, may switch to other tobacco products because of their lower price and misconception that they are a healthy alternative to cigarettes.[181,182] A study of smokers in four countries, including the United States, found that 25% believed that pipes, cigars, or roll-your-own cigarettes were safer than factory-manufactured cigarettes.[183] Such beliefs are particularly dangerous for cigarette smokers who switch to cigars or pipes, as they typically continue to inhale the smoke of the alternate product, exposing themselves to elevated levels of toxins and carcinogens.[184]

An increasing number of young people are smoking cigars.[185] A focus group conducted by the HHS Office of Inspector General found that young people

believed cigars to be more socially acceptable and easier to purchase than cigarettes.[186] A survey of African-American college students found that users preferred small cigars because of their pleasant taste and smell, positive image, and potential for stress relief, among other reasons.[187] Small cigars are a growing segment of the tobacco market: From 1998 to 2006, large cigar consumption increased 45% while consumption of small cigars increased 154%.[188] Flavored small cigars are also growing in popularity. Although the FSPTCA bans the sale of flavored cigarettes and loose tobacco intended for roll-your-own cigarettes, it does not prohibit the sale of flavored cigars or smokeless or pipe tobacco. The FDA, however, is permitted to study and regulate the products as necessary.[189] Given flavored tobacco's strong appeal to youth, all types of flavored tobaccos should be prohibited. Currently, Maine is the only state that prohibits sale of flavored tobaccos.[190]

It is important to deploy public education campaigns that strongly insist that no form of tobacco is risk-free. Public information campaigns may be part of the reason fewer smokers in the United States (compared with those in three other countries surveyed) believe that alternative tobacco products are less harmful than cigarettes.[191] Additionally, excise taxes on cigars and other tobacco products should be raised to a level that discourages price-sensitive cigarette smokers from substituting cheaper alternative tobacco products and keeps you15 -1.0909l than clo anting custer5.5 476.4974 606.4233 98owe6w73 Tc .11on,8t 1okers from16e pr

toxic chemicals found in antifreeze. Such products are unregulated and are not subject to the stringent age and marketing restrictions that limit promotion and sale to young people. Thomas P. Houston, MD, chair of the American Academy of Family Physicians• tobacco cessation advisory committee has stated, •These devices may not be marketed for cessation, but anecdotally, that•s what the public is using them for. We still don•t know the quality control, so somebody needs to be able to set standards for safety for whatever ingredients might be added and to understand what these do for the smoker in the short and the long term. Someone has to be accountable.•[200] ACP believes that since e-cigarettes deliver nicotine and may contain a host of dangerous carcinogens and chemicals, they should be aggressively reviewed and regulated by the FDA.

9. Smoking and tobacco use in movies and television should be discouraged, and the media industry should take responsibility to emphasize the dangers of tobacco use, particularly to young people.

A number of studies have concluded that depicting smoking in movies and television may influence young people to start smoking.[201] Despite decreases since the 1990s, youth exposure to smoking in the media remains a problem, and films targeted toward the youth market … those rated G, PG, or PG-13 … often depict smoking.[202] Evidence shows that reducing smoking in movies may be correlated to a reduction in teen smoking rates.[203] In an effort to curb exposure to smoking images in film, some antismoking advocates, notably the AMA and World Health Organization, have recommended that films depicting smoking be rated R, restricting viewing to older people.[204,205] Other advocates have called for a prohibition on tobacco product placement in films and have suggested that strong antitobacco advertisements be shown prior to films that depict smoking.[206] The College reaffirms its position that glamorizing smoking on television and in movies influences young persons to smoke, and this tends to reverse the trend of declining tobacco use. ACP, therefore, discourages this practice and encourages efforts to effect a more responsible attitude from the media and to emphasize the importance of education on the hazards of smoking.

Conclusion

The immense progress in reducing tobacco use has justifiably been called one of the great public health achievements of the 20th century. While smoking and tobacco use rates have declined considerably over the past 40 years, a comprehensive tobacco control and prevention effort must be undertaken and consistently maintained to ensure that a new generation of smokers does not replace those who have quit or died because of their addiction. A combination of higher excise taxes on tobacco products, better coverage and funding of smoking/tobacco cessation services, improved youth prevention efforts, prohibition on tobacco additives such as menthol, stronger restrictions on public smoking, and steady funding of comprehensive tobacco control efforts will lead to a reduction in smoking rates. There is consensus on what needs to be done to reduce the tobacco problem, but stakeholders must work to ensure that comprehensive tobacco control efforts receive the attention they need to succeed.

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