II Chronic Disease Programs to Reduce the Burden of Tobacco-Related Diseases

Justification

Tobacco use increases a person's risk for a number of diseases. Even if current tobacco use stopped, the residual burden of disease among past users would cause disease for decades to come. Addressing tobacco use reduction strategies in the broader context of tobacco-related diseases is beneficial for three reasons. First, it is critical that interventions are implemented to alleviate the existing burden of disease from tobacco, which will remain even if tobacco use is reduced among future generations. Second, the incorporation of tobacco prevention and cessation messages into broader public health activities ensures wider dissemination of tobacco control strategies. Finally, the reduction of risk factors for tobacco-related diseases other than tobacco use reduces the disease impact of tobacco use, independent of reductions in tobacco use. For example, poor nutrition, lack of exercise, and tobacco use present a greater combined risk for cardiovascular disease than the sum of each individual risk factor.

Chronic disease programs can focus attention directly on these diseases, both to prevent them and detect them early. When supported at a comprehensive level, State-based tobacco prevention and control programs can address diseases such as cancer, cardiovascular disease, asthma, oral cancers, and stroke, for which tobacco is a major cause.[1–14] However, few States have had the resources to link tobacco control activities to activities to prevent tobacco-related diseases. Examples of activities to reduce the burden of these diseases include the following:

- Implementing community interventions that link tobacco control interventions with cardiovascular disease prevention.
- Developing counter-marketing to increase awareness of environmental tobacco smoke (ETS) as a trigger for asthma.
- Training dental providers to counsel their patients on the role of tobacco use in the development of oral cancer.
- Expanding cancer registries to monitor tobacco-related cancers.

CDC's Cardiovascular Health Program provides a model framework for a broad range of program elements targeting cardiovascular disease, such as school health education programs to address tobacco use and other risk factors, community health promotion interventions, and guidance on States' efforts to target risk factors for cardiovascular disease.

Models for community-based asthma prevention programs include those cosponsored by CDC and its State and local partners, such as the California Community-Based Asthma Intervention Demonstrations Project (Fresno, CA), the Wisconsin Community-Based Asthma Intervention Project (Madison, WI), and the ZAP Asthma Project (Atlanta, GA).

Oral health programs within State and local public health programs must be expanded to address the oral health needs of disadvantaged populations. One element of effective community-based programs is the development of training for oral health intervenors to provide counseling on the oral health risks associated with tobacco use.

Cancer registry programs are working to establish standards for data completeness, timeliness, and quality. State registries also provide training for registry personnel and use a computerized reporting and data-processing system. CDC's National Program of Cancer Registries (NPCR) provides models for registries. NPCR enables cancer data to be reported by age, sex, ethnicity, and geographic region—within a State, between States, and between regions.

Budget

For each of the tobacco-related disease areas, funding needs to be available to develop the State and local infrastructure necessary to coordinate more broadly focused prevention programs as tobacco control programs expand. Best practices dictate that States allocate $500,000 to establish core-capacity functions targeting tobacco-related cardiovascular disease and an additional $1 million–$1.5 million to develop a comprehensive program. For asthma prevention pilot programs, base funding of $200,000–$300,000 is recommended for State infrastructure, training, and capacity-building activities and an additional $600,000–$800,000 to support these activities as local initiatives are developed. In addition, about $400,000–$750,000 (depending on the population of the State) should be allocated to address the oral disease consequences of tobacco use. About $75,000–$300,000 (depending on the population of the State) is recommended for the expansion of cancer registries.

Core Resources

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