Introduction

The goal of a comprehensive tobacco control program is to reduce disease, disability, and death related to tobacco use by

- Preventing the initiation of tobacco use among young people.
- Promoting cessation among young people and adults.
- Eliminating nonsmokers' exposure to ETS.
- Identifying and eliminating the disparities related to tobacco use and its effects among different population groups.

The Centers for Disease Control and Prevention (CDC) has prepared these best practices to help States assess options for comprehensive tobacco control programs and to evaluate their local funding priorities. This document draws on "best practices" determined by evidence-based analyses of excise tax-funded programs in California and Massachusetts and by CDC's involvement in providing technical assistance in the planning of comprehensive tobacco control programs in other States with excise tax-funded programs (Oregon and Maine) and in the four States that individually settled lawsuits with tobacco companies (Florida, Minnesota, Mississippi, and Texas).

Reducing tobacco use requires a partnership between the Federal government and States. The Federal government has undertaken a number of important activities that provide a foundation for State action. Scientific data about the extent of tobacco use, the impact of tobacco use, and interventions to reduce tobacco use have been generated and disseminated by several Federal government agencies including the National Institutes of Health, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, and the Agency for Health Care Policy and Research.

The Federal government has supported a number of surveys of tobacco use among adults and youth through the Centers for Disease Control and Prevention (Behavioral Risk Factor Survey, National Health Interview Survey, and Youth Risk Behavior Survey), the National Institutes of Health (Current Population Survey and Monitoring the Future Study), and the Substance Abuse and Mental Health Services Administration (National Household Survey on Drug Abuse). SAMHSA's household survey is of particular note because it will collect annual data on brands of cigarettes and other forms of tobacco used by young people and adults.

The Federal government also has sponsored research on the health impact of tobacco use, determinants of tobacco use, and interventions to reduce tobacco use. The majority of this research has been supported by the National Institutes of Health's National Cancer Institute (NCI); however, other Institutes also have been involved, including the National Institute on Drug Abuse, National Institute of Child Health and Development, and the National Heart, Lung, and Blood Institute. Besides supporting disease-specific research, NCI has supported intervention studies including mass media and school trials and large-scale demonstration projects such as COMMIT and ASSIST. The Centers for Disease Control and Prevention also supports applied research through its Prevention Research Centers; this research has a particular focus on racial/ethnic and gender differences in tobacco use determinants and patterns.

Furthermore, multiple Federal government agencies support programs to prevent and reduce tobacco use. SAMHSA implements the Synar regulation to reduce youth access to tobacco products through State-level compliance activities. FDA is implementing the minors' access provisions of its tobacco regulations through contracts with States for enforcement efforts and educational interventions, including retailer outreach and media campaigns. The Agency for Health Care Policy and Research has published clinical practice guidelines on smoking cessation and has worked with a variety of health care organizations to ensure that the guidelines are implemented. Additionally, CDC supports several programs to prevent and reduce tobacco use including the National Tobacco Control Program, which in FY 1999 will fund all 50 States, the District of Columbia, and the territories to establish core tobacco use prevention and reduction programs. CDC has also developed educational and media programs including the Media Campaign Resource Center, which makes high-quality, anti-smoking advertising materials available for use by States and organizations.

Although the Federal government has undertaken a number of critical activities to curb tobacco use, State and local community action is required to ensure the success of tobacco control interventions. In acknowledgment of the unique role that States and communities play in tobacco control efforts, these best practices provide technical information to assist States in designing comprehensive programs.

Introduction

In this guidance document, CDC recommends that States establish tobacco control programs that are comprehensive, sustainable, and accountable. This document draws upon “best practices” determined by evidence-based analyses of comprehensive State tobacco control programs. Based upon this evidence, specific funding ranges and programmatic recommendations are provided. Local analysis of each State’s priorities should shape decisions regarding funding allocations for each recommended program component. The funding required for implementing programs will vary depending on state characteristics, such as demographic factors, tobacco use prevalence, and other factors. Although the type of supporting evidence for each of the recommended nine program components differs, evidence supports the implementation of some level of activity in each program area. In general, States typically have selected a funding level around the middle of the recommended ranges. Current allocations range from $2.50 to over $10; however, no State is currently implementing all of the recommended program components fully. Approximate annual costs to implement all of the recommended program components have been estimated to range from $7 to $20 per capita in smaller States (population under 3 million), $6 to $17 per capita in medium-sized States (population 3 to 7 million), and $5 to $16 per capita in larger States (population over 7 million).

The Health Consequences of Tobacco Use[1]

Tobacco use is the single most preventable cause of death and disease in our society. Annually, tobacco use causes more than 430,000 deaths and costs the Nation approximately $50–$73 billion in medical expenses alone. Tobacco use is addictive: nearly 70% of smokers want to quit smoking, but only 2.5% are able to quit permanently each year. Most smokers start smoking as adolescents. The number of American teenagers taking up daily smoking jumped 73% between 1988 and 1996. Each day, more than 6,000 persons younger than age 18 try their first cigarette, and more than 3,000 become daily smokers. One in three teens who are regular smokers will eventually die of smoking-related causes.

Other tobacco products also have serious health consequences. Use of smokeless tobacco is associated with leukoplakia and oral cancer. Although very little was known until recently about the health risks of cigar smoking, there is now strong evidence of causal relationships between regular cigar use and cancers of the lungs, larynx, oral cavity, and esophagus. These consequences are of particular concern because in 1997, 22% of high school students smoked cigars and 9.3% used smokeless tobacco.

The risks of tobacco use extend beyond actual users. Nearly 9 of 10 nonsmoking Americans are exposed to environmental tobacco smoke (ETS). Exposure to ETS increases nonsmokers’ risk for lung cancer and heart disease. Among children, ETS is also associated with serious respiratory problems, including asthma, pneumonia, and bronchitis. Additionally, substantial evidence now links ETS with sudden infant death syndrome and low birth weight.

The consequences of tobacco use have become an issue of global concern. The World Health Organization estimates that 3 million people die every year of tobacco-related diseases. Without effective international tobacco control programs, the death toll will increase to as many as 10 million people by 2030, and 7 million of these deaths will occur in developing countries. Successful programs in the United States to reduce tobacco use will provide valuable models to help other countries successfully address the growing tobacco use epidemic.

Efficacy of Comprehensive Tobacco Control Programs: California and Massachusetts

Evidence supporting the programmatic recommendations in this guidance document are of two types. Recommendations for chronic disease programs to reduce the burden of tobacco-related diseases, school programs, cessation programs, enforcement, and counter-marketing program elements are based primarily upon published evidence-based guidelines. Other program categories rely mainly upon the evidence of the efficacy of the large-scale and sustained efforts of two States (California and Massachusetts) that have been funding comprehensive tobacco prevention and control programs using State tobacco excise taxes. Increasing excise taxes on cigarettes reduces tobacco consumption rates. But more importantly, when the excise taxes support effective community, media, and school programs to prevent tobacco use, decreases in per capita consumption will continue even if industry lowers tobacco prices to preexcise tax values.[2] The tobacco industry itself has concluded that “the California campaign and those like it represent a very real threat to the industry in the intermediate term...”[3] and “the environment for the sale and use of tobacco products in California continues to deteriorate. And because California serves as a bellwether State, tobacco-related steps taken there often find their way into other States.”[4]

Best Practices

This document provides evidence to support each of nine specific elements of a comprehensive program. However, in addition to highlighting the importance of the individual program elements, it is equally critical to recognize why these individual components must work together to produce the synergistic effects of a comprehensive program.[5] Reducing the broad cultural acceptability of tobacco use necessitates changing many facets of the social environment. This scale of societal change is a complex process that must be addressed by multiple program elements working together in a comprehensive approach. For example, school programs are effective in isolation, but evidence indicates that their efficacy is greatly increased when combined with community programs and media campaigns.[6] Through evidence-based analyses in California and Massachusetts, in-depth involvement with settlement States, and published evidence of effective tobacco control strategies, CDC recommends that States establish tobacco control programs that contain the following elements:

- Community Programs to Reduce Tobacco Use.
- Chronic Disease Programs to Reduce the Burden of Tobacco-Related Diseases.
- School Programs.
- Enforcement.
- Statewide Programs.
- Counter-Marketing.
- Cessation Programs.
- Surveillance and Evaluation.
- Administration and Management.

For each of these categories, the best practices that follow provide

- Justification for the program element.
- Budget estimates for successful implementation.
- Core resources to assist implementation.
- References to scientific literature.

All core resources listed in this document, or the contacts to obtain them, are available from CDC's Office on Smoking and Health. To request copies, please call 770-488-5705 (press 2 or 3) or send an E-mail to tobaccoinfo@cdc.gov.

General Planning Resources

Advocacy Institute Tobacco Control Project. The Money is Coming! The Money is Going! Strategic Advisory Series Online Publication. 1998. (http://www.scarcnet.org/hsap/intrmon.htm).

American Cancer Society. Advocating for State Tobacco Control: An American Cancer Society Planning Guide. June 1998.

Attorney General's Task Force. A Comprehensive Tobacco Prevention and Control Plan for Washington State. November 1998. (http://www.wa.gov/ago/pubs/Tobacco.PDF).

California Department of Health Services. A Model for Change: The California Experience in Tobacco Control. Sacramento, CA: California Department of Health Services, October 1998.

Centers for Disease Control and Prevention, Office on Smoking and Health. State Tobacco Control Highlights—1996. Atlanta, GA: Centers for Disease Control and Prevention, 1996. (Updated on http://www.cdc.gov/tobacco/statehi/statehi.htm).

Minnesota Health Improvement Partnership. Tobacco Work Group. Tobacco Use Prevention and Reduction in Minnesota: Elements, Roles and Costs of a Comprehensive Plan. December 1998.

Pierce-Lavin C, Geller AC, Hyde J, Evjy J, editors. Robert Wood Johnson Foundation and Boston University School of Medicine Working Group: Creating Statewide Tobacco Control Programs After Passage of a Tobacco Tax. *Cancer* 1998;83(12 Supplement):2659–774.

Texas Inter-Agency Tobacco Task Force. Legislative Plan. October 1998.

U.S. Department of Health and Human Services. Office of Public Health and Science. Healthy People 2010 Objectives. Chapter 3. Tobacco Use. Washington, DC: U.S. Department of Health and Human Services, September 15, 1998. (http://web.health.gov/healthypeople/2010Draft/object.htm).

References

1 U.S. Department of Health and Human Services. Office of Public Health and Science. Healthy people 2010 objectives. Tobacco use. Washington, DC: U.S. Department of Health and Human Services, September 15, 1998;3:1-24 (http://web.health.gov/healthypeople/2010Draft/object.htm).

2 Centers for Disease Control and Prevention. Cigarette smoking before and after an excise tax increase and antismoking campaign—Massachusetts, 1990–1996. *MMWR* 1996;45:966–70. (http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00044337.htm).

3 Verner KL. California antismoking campaign funding (letter), January 29, 1991. RJ Reynolds Litigation Document, Minnesota Depository, Bates No.: 507755351–5354.

4 California Department of Health Services. A model for change: the California experience in tobacco control. Sacramento, CA: California Department of Health Services, October 1998.

5 Controlling the smoking epidemic. Report of the WHO Expert Committee on Smoking Control. Geneva: World Health Organization, 1979. WHO Technical Report Series, No.: 636.

6 U.S. Department of Health and Human Services. Preventing tobacco use among young people: a report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1994.