DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
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Office on Smoking and Health
Centers for Disease Control and Prevention
4770 Buford Highway NE, MS F79
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Ms. Limtiaco,

Per your request, I am submitting this statement of the scientific evidence regarding the effectiveness of comprehensive state tobacco control programs. For the record, I am not submitting this statement for or against any specific legislative proposal.

Overview

Cigarette smoking and exposure to secondhand smoke are responsible for approximately 480,000 deaths each year in this country—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.[2] 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.[3] And since 1964, more than 20 million premature deaths can be attributed to cigarette smoking.[4] In addition to this enormous health burden, smoking also imposes a major economic burden on society, costing

[1] U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. Printed with corrections, January 2014.

[2] U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. Printed with corrections, January 2014.

[3] U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. Printed with corrections, January 2014.

[4] U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. Printed with corrections, January 2014.

the nation more than $300 billion each year, including nearly $170 billion for direct medical care of adults and $156 billion in lost productivity due to premature death.[5]

The effects of smoking on health are profound. Smokers cut over 10 years of their life expectancy, meaning they are likely to die 10 years earlier than if they had not started smoking.[6] Non-smokers are twice as likely to live to age 80 compared to smokers.[7] 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 41,000 deaths each year in nonsmoking adults, including 34,000 heart disease deaths and 7,300 lung cancer deaths.[8] In 2006, the Surgeon General concluded that there is no risk-free level of exposure to secondhand smoke.[9] Subsequent Surgeon General's reports on tobacco have upheld this conclusion. Exposure to secondhand smoke also results in considerable financial costs to society; it is estimated that secondhand smoke exposure costs the United States $5.6 billion in lost productivity every year.[10]

Best Practices for Comprehensive Tobacco Control Programs

The good news is that we know how to end the tobacco use epidemic. Chapter 14 of the 50th Anniversary Surgeon General's report recommended accelerating 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 to encourage smokers to quit.
- Extending comprehensive smokefree indoor protections that prohibit smoking in indoor worksites and public places, including restaurants and bars, to 100% of the U.S. population. This strategy is proven to protect people from secondhand smoke, decrease smoking rates, and prevent youth smoking initiation, without having an adverse impact on the hospitality industry.
- High impact mass media campaigns that shape social norms around preventing intiaition, encouraging cessation, and encouraging support for smoke-free environments.[11]

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[5] Xu X, Bishop EE, Kennedy SM, Simpson SA, Pechacek TF. Annual Healthcare Spending Attributable to Cigarette Smoking: An Update[PDF–157 KB]. American Journal of Preventive Medicine 2014;48(3):326–33..

[6] Clarke R, Emberson J, Fletcher A, Breeze E, Marmot M, Shipley MJ. Life expectancy in relation to cardiovascular risk factors: 38 year follow-up of 19,000 men in the Whitehall study. *BMJ* 2009;339:b3513.

[7] Clarke R, Emberson J, Fletcher A, Breeze E, Marmot M, Shipley MJ. Life expectancy in relation to cardiovascular risk factors: 38 year follow-up of 19,000 men in the Whitehall study. *BMJ* 2009;339:b3513.

[8] U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. Printed with corrections, January 2014.

[9] U.S. Department of Health and Human Services*. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General.* U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.

[10] U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. Printed with corrections, January 2014.

[11] U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and

The Surgeon General recommends 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.[12]

CDC first presented its recommendations regarding the components of evidence-based, effective, and comprehensive state tobacco control programs—along with recommendations for the funding required to implement these programs —in the 1999 guideline, *Best Practices for Comprehensive Tobacco Control Programs.* CDC updated these guidelines in 2007. In 2014, CDC refined this guidance based on the best available science, evidence from state experiences, and the changing tobacco control landscape to help states assess their options and evaluate funding priorities. The 2014 edition of *Best Practices* describes an integrated programmatic structure for implementing interventions proven to be effective and provides the recommended level of state investment necessary to reach these goals and to reduce tobacco use in each state. This letter will provide an overview of the recommendations in the 2014 *Best Practices* guidelines.

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.[13] This comprehensive approach optimizes synergy from applying a mix of educational, clinical, regulatory, economic, and social strategies.[14] 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.[15,16,17]

Best Practices for Comprehensive Tobacco Control Programs–2014 provides the specific annual investment recommended 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

Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. Printed with corrections, January 2014.

[12] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2014*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

[13] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2014*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

[14] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2014*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

[15] Farrelly MC, Pechacek TF, Chaloupka FJ. The impact of tobacco control program expenditures on aggregate cigarette sales: 1981–2000. *Journal of Health Economics* 2003;22(5):843–59.

[16] Tauras JA, Chaloupka FJ, Farrelly MC, Giovino GA, Wakefield M, Johnston LD, O'Malley PM, Kloska DD, Pechacek TF. State tobacco control spending and youth smoking. *American Journal of Public Health* 2005;954(2):338–44.

[17] Farrelly MC, Pechacek TF, Thomas KY, Nelson D. The impact of tobacco control programs on adult smoking. *American Journal of Public Health* 2008;89(2):304–9.

per person per year.[18] This is only 15 percent of CDC's national recommended annual investment from *Best Practices-2014*, which is $10.53 per person. [19] The recommended investment for Washington is $9.22 per capita and $63.6 million total. Including only state funds, fiscal year 2016 funding for tobacco control in Washington was $640,500, or 1% of CDC-recommended levels.[20]

These funding recommendations are miniscule when compared to tobacco industry advertising and promotion. In 2014, cigarette and smokeless tobacco companies spent more than $9 billion on advertising and promotional expenses in the United States, or nearly $25 million each day.[21] [22] Nearly 75 percent ($6.8 billion) of all cigarette company marketing expenditures were for price discounts paid to retailers or wholesalers to reduce the price of cigarettes to consumers. This is more than twice of what CDC's recommends all states spend combined on comprehensive tobacco control and prevention.

These recommended program funding levels are an unprecedented commitment to tobacco prevention and control, but the cost must be compared to the massive health and economic burden that tobacco use places on Washington. CDC estimates that smoking-related diseases kill 8,300 Washington adults every year, and that 104,000 Washington youth ages 0–17 are projected to die from cigarette smoking.[23] These diseases also impose a substantial economic burden on the state, accounting for more than $2.8 billion in medical costs every year.

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.[24] 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. An entire, comprehensive approach is most effective, and

[18] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2014*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
[19] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2014*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
[20] Campaign for Tobacco-Free Kids. FY 2016 Funding for State Tobacco Prevention Programs. Available at: http://www.tobaccofreekids.org/content/what_we_do/state_local_issues/settlement/FY2016/3.%20FY2016%20Rankings%20of%20Funding%20for%20State%20Tobacco%20Prevention%20Programs%2012.4.15.pdf
[21]Federal Trade Commission. Federal Trade Commission Cigarette Report for 2014. Washington: Federal Trade Commission, 2016. https://www.ftc.gov/system/files/documents/reports/federal-trade-commission-cigarette-report-2014-federal-trade-commission-smokeless-tobacco-report/ftc_cigarette_report_2014.pdf
[22] Federal Trade Commission. Federal Trade Commission Smokeless Tobacco Report for 2014.Washington: Federal Trade Commission, 2016. https://www.ftc.gov/system/files/documents/reports/federal-trade-commission-cigarette-report-2014-federal-trade-commission-smokeless-tobacco-report/ftc_smokeless_tobacco_report_2014.pdf
[23] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2014*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
[24] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2014*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

individual interventions have less impact and less return on investment when they are implemented in isolation.[25]

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 progress toward reducing tobacco use.
- Infrastructure, Administration, and Management to assure adequate internal capacity within states, including a sufficient number of skilled staff to provide program oversight, technical assistance, and training.

In addition to these specific components, comprehensive tobacco control programs should integrate efforts to achieve equity by eliminating tobacco-related disparities in all their activities. *Best Practices–2014* outlines examples of ways programs can do this throughout the report, 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.

Impact 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.[26]

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.[27] Longer-term investments would yield even greater

[25] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2014*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
[26] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2014*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
[27] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2014*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

effects.[28] 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.[29] 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.[30]

For every dollar spent on tobacco prevention, states can reduce tobacco-related health care expenditures and hospitalizations by up to $55.[31] The amount is dependent on program effectiveness and longevity of investment—the longer and more states invest, the larger the impact on youth and adult smoking.[32] 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.[33]

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.[34] 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.[35] 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.[36]

Impact of Funding Cuts

[28] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2014*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
[29] California Department of Public Health. Smoking prevalence among California adults, 1984–2010;http://www.cdph.ca.gov/Pages/NR11-031SmokingChart.aspx; accessed February 21, 2014.
[30] Centers for Disease Control and Prevention. State-specific trends in lung cancer incidence and smoking—United States, 1999–2008. *Morbidity and Mortality Weekly Report* 2011;60(36):1243–7.
[31] Lightwood J, Glantz SA. The effect of the California tobacco control program on smoking prevalence, cigarette consumption, and healthcare costs: 1989–2008. *PLoS One* 2013;8(2):e47145.
[32] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2014*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
[33] Lightwood J, Glantz SA. The effect of the California tobacco control program on smoking prevalence, cigarette consumption, and healthcare costs: 1989–2008. *PLoS One* 2013;8(2):e47145.
[34] Bauer UE, Johnson TM, Hopkins RS, Brooks RG. Changes in youth cigarette use and intentions following implementation of a tobacco control program. *JAMA: The Journal of the American Medical Association* 2000;284(6):723–8.
[35] RTI International. *2011 Independent Evaluation report of the New York Tobacco Control Program*. Albany, NY: New York State Department of Health, 2011.
[36] RTI International. *2011 Independent Evaluation report of the New York Tobacco Control Program*. Albany, NY: New York State Department of Health, 2011.

After the 1999 *Best Practices* report was published, overall funding for state tobacco control programs more than doubled.[37] Unfortunately, however, in the face of budget deficits and tough funding choices among 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.[38] Between 2008 and 2012, states cut tobacco prevention funding by 36 percent, or $260.5 million.[39] This eroding trend continues—the $491 million states have allocated to tobacco control in fiscal year 2017 is nearly a third lower than state funding compared to FY 2008.[40,41]

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.[42,43] 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.[44] 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 creeping up again.[45]

Conclusion

The tobacco use epidemic can be stopped. We know what works. If we were to fully implement proven strategies, we could prevent the staggering toll that tobacco use takes on our families and our communities. With sustained implementation of state tobacco control programs and policies, the Healthy People 2020 objective of reducing adult smoking prevalence to 12% or less by 2020 could be attainable.[46]

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[37] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—August 2007*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2007.

[38] Centers for Disease Control and Prevention. State tobacco revenues compared with tobacco control appropriations—United States, 1998–2010. *Morbidity and Mortality Weekly Report* 2012;61(20):370–4.

[39] Centers for Disease Control and Prevention. State tobacco revenues compared with tobacco control appropriations—United States, 1998–2010. *Morbidity and Mortality Weekly Report* 2012;61(20):370–4.

[40] Centers for Disease Control and Prevention. State tobacco revenues compared with tobacco control appropriations—United States, 1998–2010. *Morbidity and Mortality Weekly Report* 2012;61(20):370–4.

[41] Campaign for Tobacco-Free Kids. *Broken Promises to Our Children: The 1998 State Tobacco Settlement 18 Years Later*. Washington, DC: 2016. Available at: http://www.tobaccofreekids.org/microsites/statereport2017/pdf/StateReport_FY2017.pdfF

[42] Orzechowki and Walker. *The Tax Burden on Tobacco 2006*. Washington, DC: 2007.

[43] Centers for Disease Control and Prevention: Youth Risk Behavioral Surveillance System, 1995–2005.

[44] Orzechowski and Walker. *Tax Burden on Tobacco 2006*. Washington, DC: 2007.

[45] Davis KC, Crankshaw E, Farrelly MC, Niederdeppe J, Watson K. The impact of state tobacco control funding cuts on teens' exposure to tobacco control interventions: evidence from Florida. *American Journal of Health Promotion* 2011;25(3)176–85.

[46] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2014*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014

CDC estimates that 104,000 youth ages 0–17 from Washington are projected to die from cigarette smoking if we do not change course.[47] Indeed, tobacco use will remain the leading cause of preventable illness and death in Washington and in the United States until our efforts to address this problem are on par with the harm it causes.

Sincerely,

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Deputy Director for Research Translation
Office on Smoking and Health
Centers for Disease Control and Prevention

[47] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2014*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.